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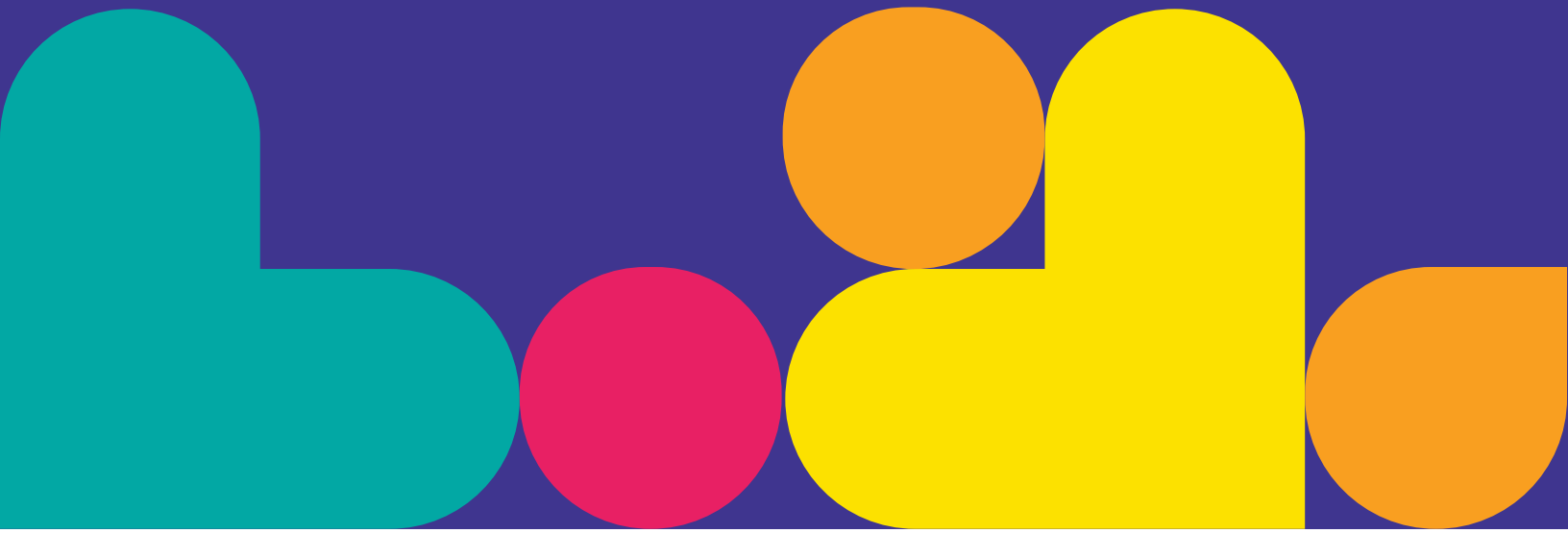
# HOW SAFE IS YOUR CARE?

## Measurement and monitoring of safety through the eyes of patients and their care partners



Healthcare Excellence Canada

## Authors

**Lianne Jeffs**

Research and Innovation Lead Scholar
in Residence Nursing and Health Disciplines
Senior Scientist Lunenfeld Tanenbaum Research Institute
Sinai Health

Associate Professor (status)
Institute Health Policy Management and Evaluation
Lawrence S. Bloomberg Faculty of Nursing
University of Toronto

**Kerry Kuluski**

Dr. Mathias Gysler Research Chair in Patient and Family Centred Care
Institute for Better Health, Trillium Health Partners

Associate Professor (Status)
Institute of Health Policy, Management and Evaluation,
University of Toronto

**Anne MacLaurin**

Senior Program Lead
Healthcare Excellence Canada

**Virginia Flintoft**

Senior Research Associate (Retired)
Institute Health Policy Management and Evaluation,
University of Toronto

Senior Program Manager (Retired)
Canadian Patient Safety Institute

**Maaike Asselbergs**

Patient Partner
Patients for Patient Safety Canada

**Dr. G. Ross Baker**

Professor Emeritus
Institute Health Policy Management and Evaluation,
University of Toronto

## Contributors

**Sinai Health- Research Staff**

Frances Bruno, Marianne Saragosa, Noah Schonewille, Marie Oliveira and Lily Zeng

**Healthcare Excellence Canada**

Ioana Popescu, Director, Safety Strategies & Programs
Maryanne D'Arpino, Vice-President, Programs & System Transformation

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Healthcare Excellence Canada (HEC) is an organization with a relentless focus on improving healthcare, with – and for – everyone in Canada. Launched in March 2021 from the amalgamation of the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare Improvement, Healthcare Excellence Canada has greater capacity to support partners to turn proven innovations into widespread and lasting improvement in patient safety and all the dimensions of healthcare excellence. We believe in the power of people and evidence and know that by connecting them, we can achieve the best healthcare in the world. HEC is an independent, not-for-profit charity funded primarily by Health Canada.

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150 Kent Street, Suite 200
Ottawa, Ontario, K1P 0E4, Canada
613-728-2238 | communications@hec-esc.ca

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# Foreword

Improving patient safety has been an important focus globally for 20 years and counting. In Canada, the creation of the Canadian Patient Safety Institute[1] (CPSI) in 2003, followed by the release of the Canadian Adverse Events study in 2004, initiated Canadian efforts to identify the incidence of unintended harm resulting from care, and to implement strategies that reduced such harm. Yet, patient safety results are disappointing in Canada and elsewhere; many of the underlying causes of unsafe care have eluded detection and, despite some successes, the interventions alone designed to improve safety have been insufficient to eliminate known sources of harm.

There have been several attempts to reorient safety strategies and improve safety interventions, engaging frontline staff, senior leaders, and board members, providing staff from "board to ward" with measures and tools that aid their efforts. Continuing slow progress in creating safe care environments has prompted detailed analysis of what "safety" entails and how to create it. Among the most thoughtful and promising analyses is the Measurement and Monitoring of Safety Framework (MMSF), offered by Charles Vincent, Susan Burnett and Jane Carthey (Vincent et al., 2013b; Vincent et al., 2014). Most patient safety literature adopts the straightforward definition of patient safety as "absence of harm." Vincent and colleagues suggest, based on their review of safety science and experiences in several industries, that healthcare needs to adopt a broader view of safety that examines the sources of resilience and capabilities that enable safe care, and endorses a less reactive approach than current efforts to improve safety. Vincent and colleagues call for a broader and more comprehensive view of healthcare safety.

Current approaches are based largely on the measurement and analysis of safety incidents and the formulation of policy and practice aimed at reducing further incidents. Understanding past harm remains important. Following research and practice in high performing systems, additional elements are needed to create systems that support and encourage safer care. These elements include the recognition of system reliability, drawing upon the literature on high reliability organizations (Chassin & Loeb, 2013; Vogus & Iacobucci, 2016; Sutcliffe et al., 2017), and resilience engineering (Fairbanks et al., 2014; Braithwaite et al., 2015). Sensitivity to operations, reflecting the importance of teamwork, communication, and frontline awareness of safety threats is another key element (Salas & Rosen, 2013; Weick & Sutcliffe, 2015), and anticipation and awareness, echoing the views of Richard Cook, David Woods and Eric Hollnagel on "foresight" and planning for failure (Woods & Cook, 2001; Braithwaite et al., 2015).

To date, these ideas have been largely tested outside of healthcare. Following the work in the United Kingdom (UK), the CPSI[1] funded two projects to trial these new safety approaches in Canada. Evaluation of these efforts suggests that the MMSF and tools created for implementation have been well received by frontline teams, senior leaders and board members and improved frontline safety practices. But there has been limited attention to how patients respond to and engage with this wider view of safety.

The current report offers a comprehensive approach to understanding patients' and caregivers' views of the Measuring and Monitoring Framework and the translation of these ideas into potential avenues for action that can reinforce and extend current patient and caregivers' engagement with safety. Champions were engaged from Patients for Patient Safety Canada, a group created to engage and bolster patients in efforts to improve safety, and from Alberta's Imagine Citizens Network as well as safety leads from healthcare organizations across Canada, to serve as advisors.

*Healthcare needs to adopt a broader view of safety that examines the sources of resilience and capabilities that enable safe care, and endorses a less reactive approach than current efforts to improve safety.*

1 In 2021, the Canadian Patient Safety Institute (CPSI) and Canadian Foundation for Healthcare Improvement (CFHI) came together to form a new organization, Healthcare Excellence Canada (HEC).

Patient safety remains a critical goal for healthcare organizations in Canada and globally. Exploring efforts, such as the MMSF, that expand safety capabilities and engage patients, staff and leaders at all levels are critical in achieving safety for all. To enable effective engagement of patients and their caregivers in all aspects of measurement and monitoring of safety, a deeper understanding of how they see safety is required. That is the aim of this report.

G. Ross Baker and Maaike Asselbergs
Co-Chairs: Pan-Canadian Advisory Committee

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# Abstract

What is commonly measured in the healthcare system isn't how safe care is but how harmful it has been.

This report outlines findings from a research study which aimed to answer, "How safe is care from the perspective of patients, families, care partners, and care providers?" A literature review, interviews, focus groups, and a World Café were conducted to help understand how patients and their care partners view safety. The Measuring and Monitoring of Safety Framework (MMSF) (Vincent et al., 2013b) was used to guide the study. The MMSF offers a broader, more comprehensive and real-time view of patient safety. The Framework helps shift away from a focus on past cases of harm towards current performance, future risks and organizational resiliency.

### Key findings include:

- Patients, their care partners and care providers articulate that safety is more than the absence of harm.
- Safe care requires a pro-active approach, with ongoing engagement of patients and their care partners.
- A number of strategies can be used to enable safer care including giving patients and care partners access to information and engaging them in safety discussions (huddles, bedside reporting, etc.)
- Care partners, volunteers, advocates, and/or a point person (provider) is required to improve communication with patients and increase opportunities for them to be meaningfully involved in their care.

### Conclusion

The MMSF represents a critical shift in how patients can enable safer care. Having patients and care partners contribute meaningfully to safety will enhance healthcare providers' view of harm and understanding of what it means to feel safe.

# Executive Summary

This report underscores the urgent need to rewire our thinking and approach to safety. Patient safety is most often defined by the "absence of harm." Vincent, Burnett & Carthey, in their report "The Measurement and Monitoring of Safety Framework" (MMSF), contend that healthcare needs to adopt a broader view of safety that examines the sources of resilience and capabilities that enable safe care and endorses a less reactive approach than current efforts to improve safety (Vincent et al., 2013a). The MMSF approach provides a broader, more comprehensive and real-time view of patient safety. The Framework helps shift away from a focus on past cases of harm towards current performance, future risks and organizational resiliency.

To better understand the role of patients and care partners, the Canadian Patient Safety Institute[2] commissioned a mixed methods research study to learn how MMSF could be applied to understand how patients and their care partners experience safety in the healthcare system and use this knowledge to influence healthcare practice.

This research report "How safe is your care? Measurement and monitoring of safety through the eyes of patients and their caregivers" consolidates much of what is important in terms of patient engagement and safety improvement. The research findings offer great promise to make a positive difference to the future of patient safety. The actions outlined in the report for each domain of the Framework offer tactics for engaging patients, their care partners, and all members of the healthcare team in meaningful and focused ways for the purpose of creating safety.

**Key Learnings**

The overarching question that guided the study was: *"How safe is care from the perspective of patients, families, care partners, and care providers?"* This report outlines the analysis of data that emerged from interviews, focus groups, and a World Café (knowledge-sharing event); and a literature review to understand how patients and their care partners view safety.

The dimensions of the MMSF were used to guide the analysis. The literature review, patients, care partners and healthcare providers offered key insights related to the five domains of the MMSF. Actions and strategies to support stronger provider-patient partnerships for past harm, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning are included.

2 In 2021, the Canadian Patient Safety Institute (CPSI) and Canadian Foundation for Healthcare Improvement (CFHI) came together to form a new organization, Healthcare Excellence Canada (HEC).

## Past Harm

### *Has patient care been safe in the past?*

What is commonly measured in the healthcare system isn't how safe care is but how harmful it has been. Measuring harm is an essential foundation but not equivalent to measuring safety. Patient safety must involve much more than measuring harm in order to prevent safety events (Vincent et al., 2013a).

Patient and public involvement in safety has been limited largely to providing feedback following a patient safety incident or poor experiences of care (Health Foundation, 2013a). Patients and care partners say that a breakdown in communication and trust, and a lack of follow-up can lead to harm and feeling neglected, uncomfortable, and dehumanized. Leaders and healthcare providers need to have an expanded understanding of harm and all people impacted by harm (patients, families, teams) should be involved in the process.

Actions to improve the approach to past harm:

- Provide patients and care partners opportunities and environments to speak up or report about harm
- Disclose, learn from and follow-up after harm
- Use patient advocates to support patients and care partners when harm occurs
- Make data more widely available related to harm, patient safety incidents and patient reported safety concerns

## Reliability

### *Are our clinical systems and processes reliable?*

Reliability is defined as 'failure free operation over time' and applies to measures of behaviour, processes, and systems. In healthcare, clinical processes and systems are often unreliable and many patients are harmed by the care intended to help them. Reliability alone is not enough to ensure safety (Vincent et al., 2013b). Staff, patients, and care partners all have a role in improving the reliability of care. Patients describe reliable care as being critical to feeling safe and they identified these provider attributes as characteristics of reliable care: being technically competent, attentive, following standards of care, adhering to personal care plans, being familiar with their care process, and well-informed of everyday routines. Having staff who were familiar with the patients and their care processes enhanced trust and created a safer care experience (Chin, 2011; Schaepe, 2017; Bergman, 2020; Costa, 2020).

Actions to improve the approach to reliability:

- Optimize patient-provider partnerships
- Learn about patients, perform regular check-ins, optimize communication during transitions in care
- Provide patients and care partners the opportunity and environments to speak up about failures of equipment, tasks, processes, interventions, and pathways
- Make it easy for patients to access their test results/health information
- Increase transparency when sharing data related to the reliability of processes that are critical to patient safety

## Sensitivity to Operations

*Is care safe today?*

Sensitivity to operations promotes early identification of problems so that actions can be taken before they threaten patient safety (Vincent et al., 2013b). It involves observing, listening, perceiving and acting on the information that is gathered in a timely fashion. A patient's perception of safety can be based on the manner of the staff, the care they take, being listened to, how staff respond to their concerns when checking details, and their empathy and compassion (Vincent et al., 2013b).

Patient and care partners want staff to treat them with dignity and respect. Patients and care partners look for a welcoming environment that openly listens to their stories, experiences, and concerns. Patients and care partners described the absence of sensitivity to operations when they felt dismissed, ignored, rushed, or had their concerns minimized.

Actions to improve the approach to sensitivity to operations:

- Create structures and processes to support patients and care partners to observe, listen, perceive, and speak up about safety and concerns with staff
- Optimize communications between patients and providers
- Create environments in which staff feel safe to speak up and feel empowered to intervene
- Build awareness and communicate the value of patients partnering with providers for patient safety
- Identify patient advocate and clinical point person

## Anticipation and Preparedness

*Will care be safe in the future?*

Anticipation and preparedness involves thinking ahead and envisioning possible problems and hazards, enabling those involved to make plans and be prepared. Clinicians skilled in anticipation and preparedness, do not rely on escaping from harmful situations but rather on trying to avoid them in the first place (Vincent et al., 2013b; MMSF e-guide, 2017).

Involving patients and their families as members of the care team is vital to a good outcome. Care partners are an integral part of the healthcare team and are often best positioned to recognize that the sometimes subtle, yet very important changes in their loved one's condition may indicate deterioration (CPSI, 2017).

With anticipation and preparedness questioning is encouraged, even when things are going well (Vincent et al., 2013b). Healthcare providers need to acknowledge that patients are experts in their own care and recognize the value of partnering with patients to co-create safe care by being collaborative, open, transparent, and sharing information.

Actions to improve the approach to anticipation and preparedness:

- Create structures and processes to support organizations, staff, patients, and care partners to think ahead, make plans and be prepared
- Optimize communication between patients, care partners and providers to support thinking ahead, making plans, being prepared, and communicating identified concerns and risks
- Leverage the role of a patient advocate and clinical point person to support thinking ahead, making plans, and being prepared

## Integration and Learning

*Are we responding and improving?*

Integration and learning constitutes a critical element of safety for patients and their care partners and healthcare providers have a responsibility to support them with this. The three critical elements of integration and learning are: capturing and integrating safety information, learning from it, and responding to it (Vincent et al., 2013b).

Of all the MMSF dimensions, healthcare providers indicated that integration and learning is the one that requires the most improvement. Many patients and care partners identified the need for providers to acknowledge errors, to be transparent about what went wrong, and what was (or will be done) to prevent future harm to patients from similar events.

To support safe care, integration and learning strategies shared by patients and care partners during the interviews and focus groups include gathering information from multiple sources, learning from different perspectives, and compiling and using the information to share with staff. Advocates can assist patients in their communications with staff as interviewees indicated "speaking up" can be intimidating and leaves patients feeling vulnerable.

Actions to improve the approach to integration and learning:

- Support patients and care partners in gathering, integrating, learning, and responding to information
- Support patients and care partners with their own integration and learning by enabling access to and ownership of information

### Conclusion

The Framework represents a critical shift in how meaningful engagement of patients and care partners can contribute to enabling safer care. Doing so will enhance care providers' understanding of patient views of harm and of what it means to feel safe.

# 1.0. BACKGROUND

## 1.1 Introduction

Efforts to reduce patient safety incidents in healthcare have focused on changing people's behaviour, changing how care is structured, and tackling specific harms (e.g., falls in hospital). However, it is believed that to deliver continuous improvement in patient safety a broader approach is necessary, that includes the promotion of safe care and explores the potential for people to be actively involved in their safety.

### Patient engagement for patient safety

Acknowledging patients and care partners as safety experts and valuable sources of information about the safety and quality of care is critical (Vincent & Davis, 2012; Patient Engagement Action Team, 2017; Daniels et al., 2012; Hasegawa et al, 2011; King et al., 2010). This view is grounded in a growing body of literature that suggests that patients and family members can help create safety and prevent harm by identifying actual and potential risks, hazards, and safety incidents that could remain otherwise undetected (Patient Engagement Action Team 2017; Hasegawa et al., 2011; King et al., 2010; Daniels et al., 2012; Iedema et al., 2012). Patients and their care partners expect to receive safe care and are increasingly, actively and meaningfully engaged in discussions and decisions concerning care, policies, programs, and service delivery (Patient Engagement Action Team, 2017; Kovacs Burns et al., 2014).

There is increasing evidence that suggests actively engaging patients and their family members in meaningful ways results in better care experiences and health care outcomes in Canada and elsewhere (Patient Engagement Action Team, 2017; Health Foundation, 2013a). Since the release of the Canadian Adverse Event Study (Baker et al., 2004), formal and informal patient groups have been formed, like Patients for Patient Safety Canada, the only pan-Canadian safety focused group. There is growing evidence to suggest these groups are having a positive impact on safety outcomes, leadership, governance, service delivery, standard development, education and more (Patient Engagement Action Team, 2017).

The future of safety in our health systems depends on conceptualizing safety more broadly and engaging with patients and care partners in both understanding safety and working with them to improve our healthcare systems (Vincent & Amalberti, 2016). Patients should expect to see information that is important to them, which reflects the safety of the service they are using today, not just how harmful it has been in the past (The Health Foundation, 2016).

> *It is a whole new way of managing safety and actually having the patient or client … involved in developing a safety plan, it is a new approach and a very effective approach. … it [is] providing services in a patient centric way and having the patient … in control of their own destiny and heavily engaged in the process … it's really opening the lines of communication and moving away from … traditional paternal healthcare where the provider knows best, to a relationship where the provider and the patient work together to achieve the best patient outcome. (Healthcare Provider 2)*

## Measurement and Monitoring Safety Framework

In their 2013 report, Vincent, Burnett, and Carthey proposed a new approach to safety, the Measurement and Monitoring Safety Framework (MMSF). The MMSF highlights key dimensions that healthcare organization should consider in its safety measurement plans and provides a starting point for discussions about what 'safety' means and how it can be actively managed (Vincent et al., 2013a). This approach introduced the concept that patients and care partners play an essential role in safety monitoring (Vincent et al., 2013b).

Members of clinical teams from Canada and the UK who implemented the MMSF have indicated that the Framework changed the language people used, gave them a more holistic view of safety, and encouraged them to reflect on how safety was actively managed in their environment (Chatburn et al, 2018; Goldman & Rotteau, 2020). The MMSF enables a shift in mindset, enhancing the understanding of safety by asking five critical questions related to a specific dimension of safety (See Figure 1) to assess whether care is safe (Vincent et al., 2013b):

1. **Past harm**
   Has patient care been safe in the past?
2. **Reliability**
   Are our clinical systems and processes reliable?
3. **Sensitivity to operations**
   Is care safe today?
4. **Anticipation and preparedness**
   Will care be safe in the future?
5. **Integration and learning**
   Are we responding and improving?

**Figure 1: Measurement and Monitoring of Safety Framework**
(Vincent et al., 2013b)

The five domains of MMSF are not independent components of a circular process starting with harm and moving along to reliability, and so on. Rather they are interconnected, overlapping concepts and when woven together create a much stronger and safer system as depicted in the illustration of a braided rope (Figure 2)

**Figure 2 – Braided rope depicting the interconnection of the five domains.**


Teams across the country have been working to advance the knowledge and experience of the MMSF in Canada since 2016. The key benefits from CPSI's[3] Measurement and Monitoring of Safety Improvement Project in Canada are described in Table 1.

### Table 1: Key benefits from MMSF Safety Improvement Project in Canada

- Changes the way we think about safety. The focus moves away from past harm to a more holistic view of safety. Provides a shared and consistent understanding of safety.
- Moves us from assurance and accountability reporting to a "practice of inquiry" and places value on soft intelligence (e.g., listening, observing, and perceiving).
- Empowers everyone to take a proactive role in safety and promotes a culture of collective responsibility for safety.
- Promotes an understanding that staff and patient safety go hand in hand.
- Recognizes and promotes the value that patients and caregivers have in creating safety.

(Canadian Patient Safety Institute, 2021)

The value of the MMSF is that it goes beyond counting harm and focuses on the present and the future of care by asking questions like: "how safe will your care be?" This is an attempt to re-wire the concept of safety. Safety is not an isolated project or endeavor; it requires a culture of collective responsibility that leverages "soft intelligence" by valuing patients and caregivers in creating safety and addressing the gap between what providers think safe care is and what patients and caregivers believe to be safe. When asked, patients and the public indicated that their relationships with staff, and how staff communicate with them, are the most important factors that contribute to feeling safe (The Health Foundation, 2016).

## 1.2 Purpose of the Study

Looking to better understand the role of patients and care partners, HEC commissioned a team to undertake a mixed methods research study to learn how MMSF could be applied to understand how patients and their care partners experience safety in the healthcare system and use this knowledge to influence healthcare practice.

3 In 2021, the Canadian Patient Safety Institute (CPSI) and Canadian Foundation for Healthcare Improvement (CFHI) came together to form a new organization, Healthcare Excellence Canada (HEC).

# 2.0. STUDY DESCRIPTION

This report outlines the analysis of data that emerged from interviews, focus groups, and World Café (knowledge-sharing event) with patients, caregivers, care providers, and organizational leaders. The dimensions of the MMSF were used to guide the analysis.

The overarching question that guided the study was: **"How safe is care from the perspective of patients, families, care partners, and care providers?"**

## 2.1. Aim and Research Questions

The aim of the analysis was to understand the MMSF from a patient, care partner, and care provider perspective, and learn how to make the MMSF actionable in practice.

## 2.2. Project Governance

A pan-Canadian Advisory Committee was established in 2019 with Maaike Asselbergs (Patients for Patients Safety Canada) and Dr. G. Ross Baker (University of Toronto) as co-chairs with representation from other healthcare system leaders across Canada. The mandate of this committee was to assist the research team and HEC to explore the question *"How safe is your care?"* from the perspective of patients, care partners and care providers. The committee provided strategic oversight throughout the duration of the research. The Advisory Committee membership is available in Appendix A.

# 3.0. STUDY METHODS

## 3.1. Study Design

This multi-stage qualitative study included a literature review, interviews, focus groups, and a knowledge-sharing event called a World Café.

## 3.2. Literature Review

The literature review looked for answers to the question: *What is known in the literature about how patients and caregivers perceive and experience safety in healthcare?* The search for literature was guided by combinations of key search terms including:

- *Population:* patient, client, caregivers/care partner, and family members
- *Concept of interest:* safety, patient safety, patient voice, patient experience, patient perception
- *Context:* healthcare system, healthcare, hospital, primary care, home care, long term care

Two research staff reviewed the abstracts of the 1,357 unique studies for relevance according to established screening criteria and identified 126 possible articles. The research staff then reviewed these 126 studies and excluded an additional 92 studies for reasons including a lack of focus on patients, or caregivers, or patient safety; not a qualitative study; or not original research (e.g., editorial or commentary). An additional four documents (systematic review [1] and grey literature [3]) that were suggested by Advisory Committee members were then included. A total of 38 documents were analyzed for themes and core categories to understand how patients and their care partners view safety.

## 3.3. Interviews and Focus Groups

The research team, working with the project Advisory Committee developed the sampling strategy for interviewees and focus group participants. The sampling strategy drew from the following cohorts:

- Patients/ care partners who were involved in patient partnership activities (e.g., Patients for Patient Safety Canada, Imagine, patient advisors etc.)
- Patients / care partners who recently experienced healthcare from any healthcare sector- acute, long-term care, homecare, primary care, mental health and addictions, maternal childcare, etc. across geographic regions in Canada
- Healthcare providers familiar with the MMSF

## 3.4. Data Collection and Analytical Plan

Members of our Advisory Committee circulated a recruitment email to their mailing lists, and a tweet was posted on social media by CPSI.[4] All the patient and care partner interviews, and focus groups opened with a brief overview of patient safety and the MMSF presented by HEC MMSF collaborative coaches. The interviews and focus groups were conducted using semi-structured interview guides framed using the key learnings/principles and dimensions of the MMSF. Participants were offered a $25 gift card for their participation.

There were 23 interviews (eight healthcare providers and 15 patient and care partners) and four focus groups (mix of 13 patients and care partners) for a total of 36 participants. Most participants were from Ontario (n = 18, 67%), followed by Alberta (n = 4, 15%), British Columbia (n = 3, 11%) and Saskatchewan (n = 2, 7%). The majority of participants were female, middle aged, highly educated, financially stable, and had been a patient or care partner for many years. See Appendix B for more demographic details.

The interviews and focus groups were conducted virtually, and following participant consent, audio-recorded and transcribed verbatim. The MMSF was used as a guide to code the interview and focus group data which is consistent with a directed content analysis approach (Hsieh & Shannon, 2005). More specifically, members of the study team independently reviewed the transcripts line-by-line using the lens of the MMSF (past harm, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning) to code the data. The literature review and World Café findings were also mapped to the MMSF dimensions.

## 3.5. World Café

To translate the findings from the interviews into practice, a virtual World Café session was held. The World Café enabled participants to share information, answer key questions and work towards developing actionable strategies for future patient safety activities (Anderson, 2011; CHI KT Platform, 2019). The World Café was held over two half-day sessions during which patients, care partners, providers, managers, leaders, and decision makers were brought together to hear about the findings, provide feedback, explore the ways these findings aligned with the MMSF and how to move the findings into practice. Participants were drawn from the interview and focus group participants, Advisory Committee members, and people identified by Advisory Committee members.

4 In 2021, the Canadian Patient Safety Institute (CPSI) and Canadian Foundation for Healthcare Improvement (CFHI) came together to form a new organization, Healthcare Excellence Canada (HEC).

# 4.0. FINDINGS

## Analysis using the MMSF

This section summarizes findings from the MMSF authors, literature review, interviews and focus groups, and World Café in separate sub-sections using the MMSF domains: past harm, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning. Integrated into each sub-section are insights offered to improving each MMSF domain. While the findings are reported by domain, it is important to recognize that a concept identified under one domain may be associated with others. To help distinguish between the domains, it may be helpful to think not only about the information gathered, but also about how and when it is used.

## 4.1 Past Harm: Has care been safe in the past?

### *What did the MMSF authors have to say about past harm?*

Patient safety experts have noted that: "Harm occurs as a result of failures in patient care, rather than from the natural progress of illness or infirmity" (Vincent & Amalberti, 2016, p.39). In the MMSF report from the Health Foundation, the authors describe various types of harm that can occur in healthcare including:

- physical harms
- harm due to under, over, or inappropriate treatment
- delayed or inadequate diagnosis
- psychological harm
- dehumanization
- hospital associated functional decline
- harms in transitions of care (Vincent et al., 2013a, Vincent et al., 2013b, Garrett et al., 2017)

What has been commonly measured in the healthcare system is not how safe care is but how harmful it has been. There is an increasing awareness that measuring the failures of the past is not the best predictor of safety today, or into the future (Health Foundation, 2013a). Measuring harm, while an essential foundation, is not equivalent to measuring safety. Patient safety must involve much more than measuring harm in order to prevent safety events (Vincent et al., 2013a).

### *What did the literature review reveal about patients' and care partners' perspectives about past harm?*

The literature review revealed that patients and care partners experienced harm that was psychological and dehumanizing in nature, including feeling silenced, dismissed, and disrespected when their concerns and fears were not acknowledged (Bishop & Cregan, 2015; Dabaghi et al., 2020; Ellegaard et al., 2020; Mazor et al.,2012; New et al., 2019). One patient described feeling like a number rather than a person; while another shared that they felt pushed aside (Bishop & Cregan, 2015). Deteriorating conditions that went unnoticed or that were not attended to led to physical harm and delays in care (CPSI, 2017).

In some cases, patients and their care partners shared information that was not taken seriously by staff (Bishop & Cregan, 2015). Others described breakdowns in communication and questioned the competency of some of the healthcare team members (Dabaghi et.al., 2020; Entwistle et.al., 2010; Mazor et al.,2012; Ottosen et al., 2019).

Collectively, the literature revealed the impact care can have on the physical, psychological, and emotional well-being of patients and care partners and confirm the types of harm in healthcare (e.g., physical harm, psychological harm, harms at transition of care, under- and over-treatment, dehumanization, delayed diagnosis, hospital associated decline) described by Vincent et al. (2013b).

### *What did patients, care partners and providers say about past harm during the interviews?*

The analysis from the interviews and focus groups also demonstrated that patients and care partners' perceptions and experiences of safety extend beyond physical harm. As noted in the literature review findings, patients and their care partners shared examples of feeling silenced, dismissed and disrespected when their concerns were ignored, or when they felt mistreated and undermined. In some cases, patients and their care partners reported that providers placed too much focus on solving the disease and not enough attention to basic, fundamental care (e.g., giving proper medication, mobilizing). In other scenarios, patients did not receive adequate care due to substandard assessments. Similar to the literature review, patients and care partners noted breakdowns in communication and trust with some healthcare team members. Lack of follow-up was also identified as a source of harm. Collectively, these scenarios impacted the physical, psychological safety and emotional well-being of patients and care partners.

> *It was very frustrating because I was quite convinced there was something going on. I mean you talk specifically about his Crohn's disease diagnosis; there is physical evidence that something [is] going on, right. …He was sick, and I had taken him to a few different doctors who all dismissed my concerns. It was very frustrating because I didn't have any place else to turn, even though I knew he needed some kind of medical help." (Patient / Care Partner 3)*

The types of harm described by patients included physical harm and delays, or misdiagnosis and delays in treatment. The physical harms cited by patients included injuries sustained from a fall, infections and medication errors which in some cases resulted in death. Psychological and emotional harm of patients and care partners was also reported, including feeling neglected, uncomfortable and dehumanized. The following narratives illustrate the past harm MMSF dimension:

> *When my husband went into the hospital twice because of uncharacteristic chest pressure and pain, hospital staff [must have told him at least] four times, "OK we've done an ECG, this is not your heart." So, he immediately feels judged and very shameful for being at a hospital when other people need care more than him … coming in the second time, … and then told again it's fine and he's pressing "Are you sure? Are we ruling out this x, y, z?" And he's just been told "You don't have that. You have heartburn." … We left and he felt totally ashamed. This affected him seeking help a third time when he was just again reassured in his own mind that heart disease was ruled out and that this was heartburn, even though it was very painful … we were away on a family vacation where he died three days later. (Patient / Care Partner 11)*

Providers interviewed identified the need for staff to have an expanded understanding of harm. They also noted that when talking about harm, all people impacted (patients, families, teams) should be involved in the discussion.

> *The Framework changed our view of harm … the different types of harm, things like dehumanization … we did a lot of work educating our staff on the different types of harm. (Healthcare Provider, 7)*

### *What did the literature review say about how to improve our approach to past harm?*

Patient and public involvement in safety has been limited largely to providing feedback following a patient safety incident or poor experience of care (Health Foundation, 2013a). To advance safety a more comprehensive understanding and approach to harm and safety is required.

Re-conceptualizing safety to incorporate patient and care partners' experiences with a broader view of harm is another strategy for maturing one's approach to harm and safety (De Brún et al., 2017). Some recommendations identified in the literature for actively involving patients in the past harm dimension are to:

- include patients and the wider public to review and audit patient concerns (Health Foundation, 2013a)
- increase transparency of, access to, and support for patients to interpret data and health information (Health Foundation, 2013a)
- create opportunity for patient groups to provide guidance on safety metrics (Health Foundation, 2013b)

One method to strengthen current approaches to patient safety is to use The Safety Measurement and Monitoring Maturity Matrix (Maturity Matrix) (Carthey and Downham, 2017). The Maturity Matrix aims to help healthcare organizations reflect on their approach to measuring and monitoring safety. Conducting a self-assessment using the Maturity Matrix is a strategy that helps healthcare organizations and teams identify gaps and strengthen areas of their systems to improve safety. The Maturity Matrix was developed to answer the question, *'How mature is our organization's approach to measuring and monitoring safety?'* The Maturity Matrix has five levels of maturity, and the goal is to ultimately achieve level five across all five dimensions.

### *What did patients, care partners, and healthcare providers say in the interviews, and the World Café about how to improve our approach to past harm?*

Patients, care partners and healthcare providers offered the following actions and strategies to support stronger provider-patient partnership for past harm:

- Provide patients and care partners opportunities and environments to speak up or report about harm
- Disclose, learn from and follow-up after harm
- Use patient advocates to support patients and care partners when harm occurs
- Make data more widely available related to harm, patient safety incidents and patient reported safety concerns

Examples for each action listed above can be found in Appendix C.

## 4.2. Reliability: Are our clinical systems and processes reliable?

### *What did the MMSF authors have to say about reliability?*

Reliability gauges the probability that a task, process, intervention, or pathway will be carried out or followed as specified. It is defined as 'failure free operation over time' and applies to measures of behaviour, processes, and systems. Although it is an essential foundation of and contributes to safety, reliability alone is not enough to ensure safety. (Vincent et al., 2013a; Vincent et al., 2013b).

In healthcare, clinical processes and systems are often unreliable and many patients are harmed by the care intended to help them. There is a great deal that can be done to increase reliability, but it is important to understand there will always be a gap between the ideal practice and the reality of care delivered (Vincent & Amalberti, 2016).

Although standard routines and procedures are often the foundation of a safe organization, there is also ample evidence that complex rules can be difficult to follow and are often ignored. Factors that contribute to poor reliability include:

- Staff accepting poor reliability as normal, thus not reporting safety issues or addressing problems
- Lack of feedback mechanisms to individuals (e.g., to staff following the completion of an incident report)
- Lack of feedback within systems (e.g., stock control for equipment)
- Lack of standardization, for example in how certain drugs are prescribed, how staff conduct transfer of accountability, and how equipment is stored
- Poor communication, both written (e.g., poor documentation of medication changes in patients' health records), and verbal (e.g., transfer of accountability interrupted)
- Lack of ownership of reliability problems, for example blaming others for failures such as neglecting to charge equipment (Burnett et al, 2011; Vincent et al., 2013b)

### *What did the literature review reveal about patients' and care partners' perspectives on reliability?*

Failures in care processes contribute to patients feeling unsafe. Reliability concerns identified by patients in the literature include: poor coordination among the treatment team, contradictions in communications, wrong identification of patient, lack of attention to patient's diet, shortage of medical supplies, equipment failures such as broken bed alarms, missed diagnoses and delays in referral and treatment, errors in prescribing, dispensing and administering medicines, errors in technical testing and treatment procedures, omissions or mistakes in communication, shortfalls in hospital cleanliness, exposure to threats from other patients, and deteriorations in condition that health professionals did not notice or take seriously (Entwistle, 2010; Dabaghi et al, 2020). In one study, patients indicated that they were hesitant to speak up about lapses in the standard of care, for fear it would lead to being labeled a "complainer" and negatively impact care (Entwistle, 2010).

Patients describe reliable care as being critical to feeling safe and suggested the following provider attributes as characteristics of reliable care: being technically competent, attentive, following standards of care, adhering to personal care plans, being familiar with their care process, and well-informed of everyday routines. Having staff who were familiar with the patients and their care processes enhanced trust and created a safer care experience (Chin, 2011; Schaepe, 2017; Bergman, 2020; Costa, 2020).

The literature also describes the value care partners bring to the reliability of care. By accompanying patients, care partners can learn about expected care and standardized procedures, such as prevention of infection, the safe use of supplies and medication. This knowledge signals that care partners are an integral and important part of the care process in the hospital environment (Bergman, 2020; Costa, 2020).

While staff may identify deficiencies in the work system structure that can contribute to unsafe care, such as lack of resources, high workload and limited hospital coordination, poor equipment, and workplace design, patients are often unaware that these conditions exist and trust that they are receiving safe care (Bergman, 2020).

### *What did patients, care partners and providers say about reliability during the interviews?*

Our analysis from the interviews and focus groups revealed poor reliability contributed to patients feeling unsafe. On the other hand, patients and care partners described examples of reliable care that contributed to them feeling safe.

> *"So, we requested that whenever the [care team] came into the room that they hummed, or sang, or did something like that. … one of the questions actually was how to help him be comfortable through unpleasant procedures, and we said sing. You have to sing. They actually put that up on his whiteboard, that it was a note thing, and they sang through every unpleasant procedure … they had the whole team singing when they had to pull the tube out for the ventilator, because that would have been unpleasant. And boy, did that mean a lot to us because not only did they hear [us], [but] they [also] overcame their own personal embarrassment in singing in front of their team members to take care of the patient." (Patient / Care Partner 3)*

This quote is an example of a patient being able to contribute to safety by identifying and communicating an error.

> *"I was told by my doctor I'm having this scan, but this piece of paper says another scan. Then, the [technician] says "You're actually right. That is not the same scan." (Patient / Care Partner 1)*

When healthcare professionals were asked "which dimension do you believe resonates the most with the families and patients that you care for and why" many identified reliability. Healthcare providers were also able to identify the importance of reliability in their daily work and its impact on safety.

> *When I help facilitate quality assurance reviews, … around … a serious clinical adverse event, … one of the first things we do as an analysis team is to look at the reliability of systems and processes. Do we have the policies, [and] procedures in place? Are they easy to follow or are staff able to follow them? Or are there work arounds and why are there work arounds? Do we have reliable equipment [and] IT systems? Is our process for whatever we're doing reliable? … and at that point it's really easy to jump to conclusions. … We have a procedure, it should've been followed, it wasn't followed. At that point … it would pretty much automatically go to blame and [say] don't do it again to an individual. But we don't take that approach. [We talk] with staff, and our patients and try to get their understanding of the event that happened to understand the context around an event. And it's always at that point where even if we seem to have really robust processes or systems, we find out the vulnerabilities within the systems. (Healthcare Provider 1)*

### *What did the literature reveal about how to improve our approach to reliability?*

Staff, patients, and care partners all have a role in improving the reliability of care. Central to improvement efforts are open conversations about the gaps between "care as written" versus "care as provided." Explicit discussion of the realities of usual care is a critical first step in improving reliability. Safety is achieved by frontline practitioners rather than imposed by standards. Rules and procedures represent a critical component of safety, and while some must be adhered to precisely, it is sometimes necessary to depart from standard procedures for the sake of safety and high-quality care. It is important to explore ways staff adapt rules to help prevent harm, because, without open discussions, daily threats and variations in standards of care cannot be fully understood and may result in targeting the wrong behaviours (Vincent and Amalberti, 2016).

Safety experts report that patients are meticulous supervisors of their self-care, and their perceptions and experiences play a significant role in their awareness of problems in healthcare settings. They alone have a privileged view as the key actor across healthcare encounters and care processes (O'Hara, 2013; Vincent & Amalberti, 2016; Dabaghi et al, 2020). Patients are well placed to provide information about the reliability of processes requiring consistency in 'human behaviour'. Patients and their families are very well positioned to offer critical information about their safety that our complex healthcare system cannot reach, collate, or respond to (Bishop & Cregman, 2010; O'Hara, 2013).

Similar to past harm using The Maturity Matrix (Carthey and Downham, 2017) to conduct a self-assessment of your organization and identifying actions to take can improve reliability.

### *What did patients, care partners, and healthcare providers say in interviews, and the World Café about how to improve our approach to reliability?*

Patients, care partners and healthcare providers offered the following actions and strategies to support stronger provider-patient partnership for reliability:

- Optimize patient-provider partnerships
- Learn about patients, perform regular check-ins, optimize communication during transitions in care
- Provide patients and care partners the opportunity and environments to speak up about failures of equipment, tasks, processes, interventions, and pathways
- Make it easy for patients to access their test results/health information
- Increase transparency when sharing data related to the reliability of processes that are critical to patient safety

Examples for each action listed above can be found in Appendix D.

## 4.3 Sensitivity to Operations: Is care safe today?

### *What did the MMSF authors have to say about sensitivity to operations?*

The MMSF dimension of sensitivity to operations dimension asks the question "Is care safe today?" Sensitivity to operations promotes early identification of problems so that actions can be taken before they threaten patient safety (Vincent et al., 2013b). It involves observing, listening, perceiving, and acting on information in a timely fashion. It is concerned with the day-to-day, hour-by-hour, and even minute-by-minute management of safety. The domain focuses on bringing together a mix of intelligence to help clinicians, managers, and leaders assess and act upon safety in real time. Success in this domain relies on trust. Teams, managers, and leaders need to be able to talk honestly about all of the influences on their ability to deliver safe, harm-free care today (UK Improvement Alliance, 2017).

In healthcare, safety encompasses more than checks of patient identity, vital signs, and medications. It must include an awareness by staff, supervisors, and management of the broader issues that can affect patient care (Vincent et al., 2013b). Sensitivity to operations can include clinicians monitoring their patients, watching for subtle signs of deterioration or improvement, and monitoring their teams for signs of discord, fatigue or lapses in standards. For managers, it can also involve being alert to the impact of staff shortages, equipment breakdowns, sudden increases in patient flow and a host of other potential problems (Vincent et al., 2013b). Sensitivity to operations has been described as a gut feeling when entering a space or a unit and things don't seem quite right.

To be effective in this domain, there must be a strong emphasis on 'usable intelligence' – intelligence that is collected in real time, communicated in a comprehensible manner, and prompts immediate action. In practice, different timescales are appropriate to different contexts. Sometimes, in clinical settings, safety needs to be monitored on a minute-by-minute basis. Managers may have to resolve the bulk of minor problems either on a daily basis, or within a week or so (Vincent et al., 2013b).

### *What did the literature review reveal about patients' and care partners' perspectives on sensitivity to operations?*

The literature review revealed that sensitivity to operations was evident when patients had confidence and trust in the staff by way of feeling taken care of and "safeguarded" (Appleton et al., 2018; Bergman et al., 2020). Being informed and prepared for processes and procedures, healthcare providers taking the time to communicate and provide information about what was happening was critical in promoting patients feeling safe (Appleton et al., 2018; Bergman et al., 2020). Staff being present, listening and responding to patient concerns was critical in creating a respectful relationship in which patients believed they were an important part of the care team (Ottosen, 2019). Patients perceive patient safety as feeling in control of their care and connected with their healthcare providers (Bishop & Cregan, 2015; Appleton et al, 2018).

The importance of trust, effective communication, being heard, empathy, compassion, and a sense of having a relationship with their healthcare provider have all been identified as important factors contributing to a positive patient experience (Appleton et al., 2018; Entwistle et al., 2010; Bishop & Cregan, 2015).

In contrast, the literature review also uncovered examples where sensitivity to operations was not apparent in care. For example, at times, patients felt like they were being passed around or treated only as a number. Patients and their care partners wanted the patient to be recognized as more than just a disease. They wanted to be engaged as partners in their care and to have their unique needs understood. A large concern voiced by patients and their care partners was the lack of involvement they had in decisions about their treatment (Bishop & Cregan, 2015).

Patients have described having "a gut feeling" that something was wrong but were hesitant or not comfortable to speak up. Some patients described feeling defeated by being silenced or dismissed when they tried to bring concerns to staff's attention, while others described not knowing how to say what they needed to communicate (Bishop & Cregan, 2015).

### *What did patients, care partners and providers say about sensitivity to operations during the interviews?*

During the interviews and focus groups, participants shared the need to establish and maintain trusting relationships, have meaningful interactions, good communications, and connections with compassionate, knowledgeable healthcare providers. Similar to the literature review, examples of sensitivity to operations from the patient perspective included staff listening, believing, and validating patient and care partner concerns. Staff treating them with dignity and respect and creating a welcoming environment for patients and care partners to openly express their stories, experiences, and concerns. Patients and care partners shared the need for providers to seek and understand their perspective. They described feeling safe when they felt they were a contributing member of the healthcare team and believed their healthcare providers "stood up for them." Other patients also described feeling safe and reassured when there was good collaboration and teamwork among the healthcare professionals.

> *I'm a really huge advocate for saying "Listen to mom because she usually knows." And especially if the patient can't speak for themselves and they have somebody – you know, in our situation where nobody knows him better than me that it makes sense for the health professionals to listen to what my concerns might be. Yeah, I had one doctor here – I love what he said, "You are the world's leading expert in [your son]. I might be, you know, very knowledgeable in neurology" (he was a neurologist), but you're the world's leading expert in [your son]. So, whatever you have to say I want to hear." … That let me know that he really respected whatever it was I had to say, whatever concerns I had to express, or anything like that. (Patient / Care Partner 3)*

> *[It was] the wee hours of the morning, and I wasn't able to get to sleep. I called the nurse to ask if I could have a sleeping pill and she said no because it had to be ordered and it was going to be a big deal – instead of leaving, she sat next to me and just talked to me about why I was having difficulty getting to sleep. It was because of anxiety about everything that was happening to me and after she left, I was able to go to sleep. I'll never forget that because she spent maybe 20 or 25 minutes [with me], and that was just such a simple treatment approach and patient-centered approach to be able to help a patient, and I'll never forget that. (Focus Group 3)*

Patients and care partners spoke of the need for advocacy during their healthcare encounter, particularly when not feeling listened to. Advocacy included helping to navigate the system, speaking up, and asking for a second opinion.

> *[A fellow looked at me and said,] "Do you mind? I need to ask you to leave the room," when [they] wanted to ask [my son] some questions. [My son] was very weak and was getting really tired of going from one practitioner to another. It was great that [my son] looked at them and said, "No. My mom is my advocate, because I can't remember everything right now." (Patient / Care Partner 1)*

Patient and care partners also provided examples of care in which sensitivity to operations was missing. For example, at times, patients felt dismissed, ignored, or had their concerns minimized. Others described feeling like staff were rushed or not interested in listening to what they had to say. Some patients felt disrespected by staff, not treated with dignity, given credit for the knowledge they had about their own condition, or considered a valuable member of the care team.

> *I remember who stood by the door while they were talking to us. They stood right in front of the door with their hand on the doorknob like they couldn't get out of there fast enough. That made [me] feel like they weren't really interested to hear what the issue was and that they weren't willing or able to take five minutes to dig a little deeper … So, you want to feel like the doctor's actually giving you their attention and not just trying to get through this appointment so that they can get out of there and get on to whatever's next. (Patient / Care Partner 3)*

Poor sensitivity to operations was apparent in environments in which patients and care partners did not feel empowered to speak up or feel safe to ask questions. Similarly, their observations of poor teamwork among staff left patients feeling unsafe. For example, one patient described organizational hierarchies or perceived policies as interfering with staff's ability to advocate for patients.

> *Another thing in terms of safety that I think is really important to what I experienced was the powerlessness of staff. It really struck me how little authority people felt they had … It was related to loyalties, so they didn't want to cross somebody else's decision, whether it was the physicians or whether it was the team leaders, or just the other person on the other side of the unit. Even though that there was a life … at risk there, and even though they kind of agreed with me … they didn't feel they wanted to cross that line. One LPN [licensed practical nurse], slipped me a little piece of paper with mom's electrolytes and vital signs for the day. And she said to me, 'I don't know if I should be doing this, but I'm just going to give you this'. So, I thought my gosh, you know this was a secret kind of a way of operating because she was the LPN, and there was an RN that she didn't want to cross … the line with her, even though there was a life at stake, that was the way they operated. (Patient / Care Partner 2)*

Staff are instrumental in creating environments in which patients and care partners feel safe. This involves engaging, partnering, listening, being timely and responsive, and encouraging them to speak up and be active participants in their care. Staff communicating with their patients about safety is key to creating this type of environment. However, staff often express discomfort in approaching the topic of safety with their patients.

> *Patients and their families are invited to huddles. It is not very often that they attend, but they were always invited … I did spend some time with the families, and I asked them, "what have you seen or heard in the past 24 hours that made you feel safe or unsafe?" I would ask that question of patients and their families, and I would encourage my staff to ask that question as well when [they are] in the room. (Healthcare Provider 5)*

Engaging and co-designing with patients and care partners in safety work requires equal partnership. Patients and care partners provide key insights and perspectives of which healthcare providers are unaware.

> *Now take a patient in a hospital bed who's at risk of a fall. We don't empower that patient the same, and I think that's what we learned from the [MMSF]. Now, that is how we shift that empowerment – instead of every three months looking at the number of falls on [the unit], oh we had 180 falls, when the bedrail was up. Instead of looking at it that way, why not look in the moment of time, empower the patient to be heavily involved … And we're starting to do that and we're seeing the positive results … it's the shift in mindset. (Healthcare Provider 2)*

Also, critical to safety is creating a culture where staff feel safe to speak up and advocate for their patients.

> *… I think in healthcare there is a dominance by professions and the physician is not always right, which may sound like a bad thing to say. I think you have to create the right platform for the conversations that need to happen and start to break down some of those traditional, role-based boundaries where people don't feel comfortable because of professional hierarchy, or where they don't feel like they're able to say something or to speak up. (Healthcare Provider 6)*

## *What did the literature say about how to improve our approach to sensitivity to operations?*

Sensitivity to operations has two critical components, gathering safety information and acting on it in a timely manner. Success in this domain requires individuals and teams to maintain awareness and to be constantly alert for problems. Healthcare staff and organizations use a variety of formal and informal approaches to draw out safety information (Vincent et al, 2013b). Suggested methods for capturing safety information from patients and care partners includes having purposeful conversations about safety, such as inquiring about their experience and feelings (Bishop & Cregan, 2015; Entwistle et al., 2010; Ottosen et al., 2019; Franco et al., 2020). As a part of this process, staff need to create the environment in which patients and care partners are encouraged to observe, listen, perceive, and communicate risks and concerns with staff (Bishop & Cregan, 2015; Entwistle et al., 2010; Ottosen et al., 2019).

Likewise, healthcare leaders need to create similar environments in which staff feel safe to advocate for their patients, speak up when they identify safety concerns, and feel empowered to intervene. Teams, managers, and leaders need to be able to talk honestly about all of the influences on their ability to deliver safe, harm-free care today (UK Improvement Alliance, 2017).

Traditional healthcare delivery models are a barrier to timely action and intervention in which response times are slowed due to decisions being made at monthly or quarterly committee meetings. Healthcare organizations need to establish structures and processes to ensure usable safety intelligence is gathered and acted on in a timely way (Vincent et al., 2013b).

Structures and processes that support sensitivity to operations in healthcare include the following:

- Safety walk-rounds – an important source of safety intelligence, where senior managers discuss safety concerns with the workforce
- Using designated patient safety officers – clinicians and others with a specific role to actively seek out, identify, and resolve patient safety issues on their clinical units
- Meetings, handovers, rounds, and safety huddles – opportunities for cascading patient safety information within and across staff teams and between staff and patients or care partners
- Day-to-day conversations – informal dialogue between healthcare teams and managers, used to identify attitudes and behaviours that could indicate poor team safety culture
- Patient interviews to identify threats to safety – highlighting practical difficulties and harm experienced by patients that might not be immediately obvious to staff

(Vincent et al., 2013a)

As previously discussed, the Maturity Matrix (Carthey and Downham, 2017) is a powerful tool that can be used to assess how mature your organization is relative to sensitivity to operations.

### *What did patients, care partners, and healthcare providers say in the interviews, and the World Café about how to improve our approach to sensitivity to operations?*

Patients, care partners, and healthcare providers offered the following actions and strategies to support stronger provider-patient partnerships for sensitivity to operations:

- Create structures and processes to support patients and care partners to observe, listen, perceive, and speak up about safety and concerns with staff
- Optimize communications between patients and providers
- Create environments in which staff feel safe to speak up and feel empowered to intervene
- Build awareness and communicate the value of patients partnering with providers for patient safety
- Identify patient advocate and clinical point person

Examples for each action listed above can be found in Appendix E.

## 4.4 Anticipation and Preparedness: "will care be safe in the future?"

Information gathered from sensitivity to operations can often help heighten anticipation and preparedness. Of the five domains, the overlap and interconnectedness between these two domains may be more apparent, however the difference lies in how and when information is used.

### *What did the MMSF authors have to say about anticipation and preparedness?*

Anticipation is the ability to anticipate problems, and preparedness is the ability to be prepared for problems. It involves thinking ahead and envisioning possible problems and hazards, enabling those involved to make plans and be prepared. The ability to anticipate and respond is an essential part of delivering safe clinical care. In clinical work, treating complex, fluctuating conditions requires thinking ahead and being prepared to adjust treatment as a patient's condition changes. This skill is taught and generally well-developed among clinical staff. Clinicians skilled in anticipation and preparedness do not rely on escaping from harmful situations but rather on trying to avoid them in the first place (Vincent et al., 2013b; UK Improvement Alliance, 2017).

Considering the safety of an organization requires a broad vision, however anticipation and preparedness is less developed at an organizational level. Clinicians and managers need to use information to anticipate the safe functioning of the organization in which they work, assessing the hazards and taking action to reduce risks over time. Safety, from this broader perspective, requires anticipation, preparedness, and the ability to intervene to reduce risks at the unit, department, or systems level (Vincent et al., 2013b).

There is no shortage of safety-related information that can be used to anticipate whether care will be safe in the future. However, the extent to which this information is used varies across healthcare organizations and between care settings. Healthcare organizations invest considerable time reporting, reviewing, and analyzing past incidents and not enough time in predicting risk (Vincent et al., 2013b). In many cases, commonly used methods of anticipating harm have become box-ticking exercises, which dulls their effectiveness. They are often narrow in focus, have limited input from staff, patients and care partners and often produce actions which are not implemented (UK Improvement Alliance, 2017).

### *What did the literature review reveal about patients' and care partners' perspectives about anticipation and preparedness?*

Patient preparedness has been described as an ongoing process of knowledge-seeking, realizing, adapting to, and anticipating upcoming events (Bergman, 2020). In the literature review, feeling informed, prepared, and being an active partner with shared responsibility was instrumental in helping patients and care partners feel safe. Patients described that being equipped with information and including them in explanations made them feel calm and reduced their stress and anxiety. Furthermore, staff's willingness to share information with patients contributed to their trust and confidence in them (Bergman, 2020).

Anticipation and preparedness can become more developed in patients undergoing regular treatment. As they become familiar with their healthcare regime, they can contribute to safety through their ability to monitor, detect and speak up about problems (Entwistle et al., 2010).

Anticipating or receiving a positive response facilitates 'speaking up' (Entwistle et al., 2010). However, being a patient can engender a sense of disempowerment or subordination, where patient feedback is not seen as proper or credible evidence (Health Foundation, 2013a). Patients may be hesitant to speak up if they anticipate a negative reaction from staff. They often worry that speaking up might result in staff labelling them as difficult and being less willing to care for them in future (Entwistle et al., 2010). It is critical that staff treat patient feedback as jewels of information, and to ignore the patient is to ignore the most important safety barometer. Issues that patients raise can be an early warning to a risk (Health Foundation, 2013a).

Bergman et al. (2020), highlight that patients' perceptions of safety often differ from staff. Staff can describe a process or procedure as unsafe and demanding, whereas patients may describe the same process as safe. This highlights that patient's trust in staff and the healthcare system can give them a false sense of security (Bishop & Cregan, 2015; Bergman, 2020). Once a patient safety incident occurs, many patients and care partners become more aware of potential patient safety issues and identify the need to be more vigilant when receiving care (Bishop & Cregan, 2015). However, patients and care partners should be vigilant and be able to contribute to safety through the entire care process, not just after a patient safety incident has occurred. Patient preparedness is a critical component of safe healthcare.

### *What did patients, care partners, and providers say about anticipation and preparedness during the interviews?*

In interviews and focus groups, participants described that it was important to be informed, prepared, and an active partner with shared responsibility and power. When staff explained processes to patients, it helped prepare them for what to expect, "anchored" them in the moment, and helped reduce stress.

Patients and care partners identified the need to be proactively alert and knowledgeable about safety. Many did not realize that care could be unsafe until they experienced harm and thus became more vigilant in anticipating future risks and safety threats. This included monitoring, recognizing, and acknowledging signs of danger or deterioration. Patients and care partners who experienced past harm also spoke of the need to do their research to help prepare for future healthcare encounters and to overcome any hesitancy to ask questions.

> *You need to be alert and knowledgeable about safety before you ever need it. Right? It's about … anticipation and preparedness … we will accept and focus on safety as one of the things we will worry about because it matters to everyone, and it needs to matter before you actually need it to matter. (Patient / Care Partner 12)*

> *Had I not had the harm experiences I probably still would have approached health care systems with that same level of trust that I had originally. But I don't. So, in terms of me entering the healthcare system I guess I am … with a degree of – not cynicism but with a higher degree of critique than maybe the average person. So … if I'm going in, I've done my homework and I'm prepared to have those conversations with the provider. (Patient / Care Partner 2)*

Regardless of whether they experience harm, patients go through the process of anticipating and preparing for their own healthcare decisions. It is critical that healthcare providers acknowledge patients as experts in their own care.

> *As a patient during COVID you have to decide what appointments you have to go to in person, what ones can be put on hold, and what ones can you do by phone, and what harm or risk are you putting yourself in by not doing those appointments. (Focus Group 3)*

Patients experienced with healthcare systems are often able to recognize system vulnerabilities. Patients and their care partners become skilled at anticipating their healthcare needs and when they need to advocate to have their needs met. Patients and care partners recognized the value of having an advocate with them to take an active role in providing information and being those second eyes and ears.

> *But I thought to myself that there are a lot of people out there who come into the healthcare system and they're alone … I think it's really important … it should be part of the questions when a person enters into the healthcare system, do you have an advocate? … It can be a husband or a daughter or a son or somebody who's going to be taking an active role in providing information, in being those second ears and eyes because … they don't absorb a lot of essential information and then they're expected to go home and apply the information that they didn't really get to begin with. (Focus Group 1)*

Patients and care partners were able to provide examples of healthcare providers anticipating their future healthcare needs and helping patients prepare.

> *My wife and I were about to embark on a trip to Europe and my leg still needed to have flushing every second day and re-bandaging and that sort of thing, … they taught my wife how to do it, and so we travelled. We travelled with a suitcase filled with surgical water, syringes, band-aids and stuff like that. (Patient / Care Partner 13)*

> *The coroner … arranged an autopsy, did the report, and made recommendations for … internal reviews, [and] talked with me about if you're going to write a letter, if you're going to follow up then you know, just some tips a little bit. And he was really human and that was probably the only human in this whole process that you know. (Patient / Care Partner 11)*

Similarly, patients and care partners were able to provide examples of healthcare providers not anticipating their healthcare needs and not properly preparing them for what to expect. This included healthcare providers not identifying and acknowledging patients' rights and freedom to live at risk.

> *Freedom is important to me. My mother would have rather fallen than be confined in that wheelchair. I know that because I know her. And so, it's a question of risk versus reward. But I should have the choice. You know, people have different appetites for risk. And who is to decide? Do we make decisions around safety based on, as I say, the numbers, the things that are easy to measure? So, the number of falls, for example. Or do we make decisions around safety based on happiness? (Patient / Patient Partner 9)*

In the interviews, healthcare providers described events related to anticipation and preparedness which were either at a patient/clinical level or an organizational/system level. The discussions revealed that providers had greater success in applying this domain at a clinical level rather than at a system level. Providers spoke of the value of partnering with patients to co-create safe care by being collaborative, open, transparent and sharing information. Providers recognized patients appreciated being part of the planning process and saw they would use information to help them make informed decisions. Furthermore, providers anticipated patient needs and the potential for harm, and implemented strategies to help mitigate them.

> *Sometimes staff are afraid to actually say, "You have kidney disease, your kidneys are going to fail, eventually [you] will need dialysis." But what the patients have said is, "Give us the information upfront so we can make an informed decision." So, to me that's a bit of a gap that we have had to close, and we've actually redone our education model lately to better meet that need. (Healthcare Provider 6)*

This healthcare provider account is an example of anticipation and preparedness that reinforces the value in partnering with patients and care partners for creating safe care.

> *We had patient … who had COPD, bad from mining … He's 58 years old, worked in the mines, … since he was 16. And basically, his local doctor … and specialist, had given up on him. Basically, your COPD has progressed to the point that you're not going to recover, and here's what you gotta do living out your remaining days with low quality of life. So, we signed him up to the program and … the frontline team was working with him in helping him manage his chronic disease. We were able to not only help manage say a steady state, [but we also] helped him to improve through better management. And then after a month or so, his quality of life started to improve and then he started … thinking around safety. So as his quality of life started to improve, he was [the] guy who was going in the woods, fishing, and hunting, and that was what he normally did at the cabin … working with our clinical team, he started to develop his rescue kit that he had placed strategically depending on where he was. So, if his condition were to exacerbate, he would prepare himself to have puffers located in different areas and different methods of bringing himself back from an acute flare up. And he did that very effectively, he placed these kits all over the place, working with his clinician, … we were able to work to improve his outcome and his quality life …. And working with the team and understanding how care was delivered, he was able to develop a rescue plan or safety plan on his own. Just through the mindset of working with the clinical team and placing himself in the middle of it as an active participant. Being able to understand when he could be in an unsafe position and what he needed to do to protect himself. (Healthcare Provider 2)*

Healthcare providers spoke of system failures related to lack of anticipation and preparedness. They also provided examples of being able to predict patient needs and anticipate the potential for harm, but the complexity of the system prevented them from preparing and responding in a timely manner.

> *If you're not fully staffed … I think it's an unstable work environment and creates a very different mindset that if you go to work and you already know that you're going to be behind the eight ball, or you're not able to do the work in a manner in which you would like to do it. (Healthcare Provider 6)*

> *So maybe you need to talk to your staff at the frontline and see what's going on, and maybe look forward and see what might happen in the future as opposed to what did happen in the past." … I think that really helped me in terms of just legitimizing to others why safety is important and not just looking at past incidents. (Healthcare Provider 4)*

### *What did the literature say about how to improve our approach to anticipation and preparedness?*

Some of those involved in testing the Framework indicated that anticipation and preparedness is the hardest of all to understand and make a reality (UK Improvement Alliance, 2017). "Building capability within this domain should be a constant cycle of development, driven by reflection and the development of systems to enable it. Developing more anticipatory safety capability should be a strategic goal for departments, organizations and systems; one that builds towards an organizations newly expanded understanding of safety" (UK Improvement Alliance, 2017, pg. 29).

There is no special type of information that is suitable or unsuitable for reflecting on future hazards and potential problems. Anticipation and preparedness require that questioning is encouraged, even when things are going well, and creating opportunities for staff, either individually or in teams, to think about potential problems and hazards, and to communicate their concerns (Vincent et al., 2013b, Vincent et al., 2014).

Involving patients and their families as part of the care team is vital to a good outcome. It is well established that family members are a vital part of the healthcare team and are often best positioned to recognize the sometimes subtle, yet very important changes in their loved one's condition that may indicate deterioration. Though they may not know what is wrong, they do know that something just is not right (CPSI, 2017). The need to seek out the patient voice in a timely fashion is essential as a warning mechanism for healthcare professionals to the signs of deteriorating status and quality of care (Vincent et al., 2014).

Completing the Maturity Matrix (Carthey and Downham, 2017) with your staff will help identify opportunities for strengthening anticipation and preparedness.

### *What did patients, care partners, and healthcare providers say in the interviews, and the World Café about how to improve our approach to anticipation and preparedness?*

Patients, care partners and healthcare providers offered the following actions and strategies to support stronger provider-patient partnership for anticipation and preparedness:

- Create structures and processes to support organizations, staff, patients, and care partners to think ahead, make plans and be prepared
- Optimize communication between patients, care partners and providers to support thinking ahead, making plans, being prepared, and communicating identified concerns and risks
- Leverage the role of a patient advocate and clinical point person to support thinking ahead, making plans, and being prepared
- Build awareness and communicate with patients about potential for harm in healthcare

Examples for each action listed above can be found in Appendix F.

## 4.5 Integration and Learning

### *What did the MMSF authors have to say about integration and learning?*

The MMSF dimension of integration and learning asks the question "are we responding and improving?" This dimension can be considered the glue that holds safety together (UK Improvement Alliance, 2017), linking information garnered from the other four dimensions to create integrated lessons for improving safety. The three critical elements of integration and learning are: capturing and integrating safety information, learning from it, and responding to it.

Key questions related to this dimension are:

- How do we integrate patient safety information collected by healthcare organizations?
- How do we analyze and learn from it in a meaningful way?
- How can patient safety information be used to support a timely response and implementation of sustainable improvements? (Vincent et al., 2013b)

At all levels of the healthcare system, information gained on improving safety needs to be collected and meaningfully analyzed to draw lessons to inform improvements. Furthermore, organizations should consider sharing safety information with the patients, care partners and the public to allow them to view and make assessments (Vincent et al., 2013b).

### *What did the literature review reveal about patients' and care partners' perspectives about integration and learning?*

Integration and learning constitutes a critical element of safety for patients and their care partners and healthcare providers have a responsibility to support them with this. Initiatives to improve patient safety have primarily focused on staff reporting and learning from safety problems (Entwistle, 2020). However, learning from patient safety incidents and from efforts to improve reliability, situational awareness, and anticipation and preparedness are critical for patients and their care partners. Bishop and Cregan (2015) noted in their paper that if healthcare providers do not have a conversation about what went wrong following a patient safety incident it will result in families feeling frustrated and in need of more answers and follow-up.

Efforts to improve patient safety have attempted to include patients since the early 1990s, with the most widespread approach being centered on encouraging patients to speak up. Patients speaking up can be beneficial to safety, but only if staff integrate, learn and act on the information patients give them (Entwistle, 2010). Moreover, Entwistle's (2010) research highlights that patients' willingness to speak up was influenced by how they anticipated staff would respond. Some patients reported speaking up, and having staff listen to them and act promptly to address the issue. Unfortunately, however, other patients reported their attempts to voice concerns went unheeded which resulted in patients backing down, accepting substandard care, and leaving concerns and problems unresolved or exacerbated.

Integration and learning is essential for patients and their care partners to help manage their situations. Healthcare providers must inform patients about current and future plans for treatment, and patients need to receive the right amount of information at the right learning level and time. Observing others going through a similar treatment provides an opportunity for patients and care partners to integrate and learn. Witnessing others provides a reference point for patients and their care partners to help inform behaviour, actions, and decisions. It enables them to develop an understanding of care, treatment, and facilitates the normalization of their experience (Appleton, 2018).

### *What did patients, care partners and providers say about integration and learning during the interviews?*

The desire for integration and learning was apparent in the interviews and focus groups. Many patients and care partners identified the need for providers to acknowledge errors, to be transparent about what went wrong, and what was (or will be done) to prevent future harm to patients from similar events. Despite patients and care partners having a strong desire for transparency, reporting, and learning from harm, we learned from our interviews with patients that this did not consistently occur.

> *I would accentuate restorative justice because without that we, people like us, are left fighting our whole lives and our loved ones die every day over and over again. Every time we have to say, "But listen to me, this is what happened. But listen to me, that doesn't make sense." … the fact that someone is dead, you can't assume they're voiceless …Sometimes the way I've been treated throughout this whole process, I feel like I'm in a corporate fight … Somebody has to take responsibility for medical harm. They just do. Otherwise, the harm will just keep eating away and you can't grieve, you can't heal, you can't trust, you don't feel heard … And no matter if you win or lose, you'll always lose because your loved one has gone, and no one's taken responsibility. (Patient / Care Partner 11)*

> *… everyone can take the time to say, 'how was your experience today, is there anything that we could do different?' and then honouring that question and making sure that if something can be done that you are [circling] back and having the conversation with the patient and family. (Healthcare provider 6)*

We also heard from healthcare providers that of all the dimensions in the MMSF, integration and learning is the one that requires the most improvement.

> *I think if you leave out any one of the dimensions, you don't get the full impact, or your full potential. If you don't look at the past harm, you're missing out big opportunities, if you aren't looking at the reliability of your systems and processes, because you need that shared and consistent way to think about patient safety. If you're not talking to people and trying to understand their own environment, you'll never truly understand, as a leader, what barriers you need to help them overcome. You have to give your team that ability to anticipate and prepare for harm. And then in the end, if you're doing all those things wonderfully, [but] you're not integrating or learning or responding and learning, how can you hope to improve? (Healthcare Provider 1)*

From the interviews and focus groups, we were able to identify examples of how patients and care partners integrated and learned to support safe care. They did this by gathering information from multiple sources, learning from different perspectives, and compiling and using the information to share with staff. The interviewees recommended that patients with limited capability to gather information would benefit from having a care partner or advocate to assist them in the collection and integration of information, learning and responding throughout their healthcare journey. Advocates can assist patients with their communications with staff as interviewees indicated "speaking up" can be intimidating and leaves patients feeling vulnerable.

### *What did the literature review reveal about how to improve our approach to integration and learning?*

Safety information can come from multiple sources, which can make it difficult to know how to integrate the sources and types of data or what weighting to give them. Traditional sources of safety data can come from incident reports, administrative data, patient reported concerns, and insurance claims. To strengthen integration and learning it is important to also consider information that comes from clinical audits, analyses of routine data, observations of behaviour, and informal conversations with patients, families, and staff across the organization (Vincent et al., 2013b).

In healthcare, learning from incidents depends on incident management reporting and review processes. An ideal incident management system should include reporting, analysis, learning, feedback, and action. However, many healthcare organizations focus primarily on data collection to the detriment of other aspects of the process. Vincent et al, (2013b) emphasize improving an organization's incident analysis process will contribute to a more mature approach to integration and learning.

Timely feedback is another critical element of integration and learning as it keeps staff, patients and care partners engaged and reinforces that their concerns are being taken seriously. (Vincent et al., 2013b). Finally, to improve integration and learning, healthcare organizations should collect, use, learn from, and act on safety information at the appropriate level such as in clinical teams, units, departments, divisions, and at the executive and board level. (Vincent et al., 2013b).

Completing the Maturity Matrix (Carthey and Downham, 2017) with your staff will help identify opportunities for strengthening integration and learning.

### *What did patients, care partners, and healthcare providers say in the interviews and the World Café about how to improve our approach to integration and learning?*

Patients, care partners and healthcare providers offered the following actions and strategies to support stronger provider-patient partnership for integration and learning:

- Support patients and care partners in gathering, integrating, learning, and responding to information
- Support patients and care partners with their own integration and learning by enabling access to and ownership of information

Examples for each action listed above can be found in Appendix G.

# 5.0. DISCUSSION

Over the past 20 years, the dominant perspective on patient safety has been "the absence of harm." Measures of safety are mostly based on the numbers of patient safety incidents, and safety strategies derived from the analysis of those events and the identification of ways to reduce system and individual vulnerabilities that permit harm. This approach to safety continues to be valuable, but insufficient.

By definition, a focus on past harm is retrospective and designed to improve safety and learning after the fact. By contrast, the MMSF enables a broader lens on safety that incorporates past harm, but also raises awareness of current threats and heightens opportunities for collective vigilance and action. The MMSF has been designed and used primarily by care providers and healthcare leaders. Our study illustrates that the MMSF can also assist patients and care partners to identify many concrete examples of what safe care should look like in day-to-day practice and the actions and approaches that could increase their safety in their daily healthcare experiences.

Several MMSF domains can be simultaneously activated and strengthened through specific approaches to care delivery by working with patients and care partners as members of the care team. This partnership supports and enables them to ask questions, share concerns and co-create a workable care plan. Collaborative and responsive care can be enabled by engaging providers who consistently demonstrate respect and who view the experiences of their patients and care partners as valuable inputs in designing their care. Bedside rounding and huddles with patients and care partners were recommended as ways to create environments for them to interact with providers. In the absence of strong partnerships, patients and care partners often resort to creating their own tools and strategies to assert their interests in their care or don't engage at all. The role of patients and care partners is pivotal in creating safe care. Providing an open space for patients and care partners to identify issues and discrepancies is required so they don't feel reprimanded for speaking up. Patients and care partners can be supported to deliver safe practices themselves, particularly following a transition from hospital, with the caveat that this does not create a transfer of burden with no support from the care team.

Also outlined was the importance of team culture and dynamics, including the importance of staff feeling comfortable speaking up and outlining issues or behaviours in their fellow care providers or leaders that may be creating unsafe experiences or risks. Thus, creating a culture of safety requires an enabling context. To that end, there is an important role for organizational leaders to set the tone and create capacity for staff to openly discuss, debate and share lessons learned as a normal part of everyday practice.

# 6.0. LIMITATIONS

While we generated rich insights from patients, caregivers, providers, and leaders from across Canada (including both men and women from a range of age groups), our convenience sampling approach means we did not have a sample that was diverse across equity characteristics (e.g., race, gender, sexual orientation, language spoken, and socio-economic status) which limits the transferability of our findings. Further, our literature review focused on qualitative studies that elucidated patients and care partners' perspectives and experiences associated with their safety in healthcare, thus quantitative data was not included and only three hand-picked grey literature and one systemic review were included which may also be a limitation.

# 7.0. CONCLUSION

This study underscores that there is an urgent need to continue to rewire our thinking about and approach to safety. Collectively, the way we have dealt with patient safety is not enough. We need to make better gains in patient safety.

The Measurement and Monitoring of Safety Framework consolidates much of what is important in terms of patient engagement and safety improvement. The Framework offers great promise to make a positive difference to the future safety of healthcare in conjunction with existing patient safety frameworks, practices and resources. It is a means for engaging patients and all members of the healthcare team, day-to-day, in a meaningful focused dialogue and action on safety. It calls on all involved to answer-in-the-moment: has care been safe in the past? Are our clinical processes reliable? Is care safe today and will it be safe in the future? Are we responding and improving based on what we are learning?

The Framework represents a critical shift in how patients engage in enabling their safer care and the way all involved in that care think about, plan, and equip that shared quest. Engaging in conversations with patients about safety is not easy. By having patients and care partners contribute meaningfully to safety improvement, we can evolve a better understanding of how we see harm, and what feeling and being safe means to patients, care partners, and healthcare providers.

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# APPENDIX A: Pan-Canadian Advisory Committee Membership

## Co-Chairs

- Dr. G. Ross Baker, University of Toronto
- Maaike Asselbergs, Patients for Patient Safety Canada

## Researchers

- Dr. Lianne Jeffs, Sinai Health System
- Dr. Kerry Kuluski, Trillium Health Partners

## Members

- Developers of the Measuring and Monitoring Safety Framework, Susan Burnett and Jane Carthey from the Centre for Patient Safety and Service Quality (CPSSQ), Imperial College London
- Sarah Garrett, Co-Facilitator of the CPSI Measuring and Monitoring Safety Demonstration Project and Safety Improvement Project
- Anne MacLaurin, Canadian Patient Safety Institute[5], now Healthcare Excellence Canada
- Virginia Flintoft, Canadian Patient Safety Institute
- Kathy Kovacs Burns, Patients for Patient Safety Canada
- Susan Brien, Ontario Health
- Markus Lahtinen, Health Quality Council Alberta
- Jenny Lacroix, Canadian Institute for Health Information
- Doreen MacNeil, Canadian Institute for Health Information
- Michelina Mancuso, New Brunswick Health Council (Retired)
- Lena Cuthbertson, British Columbia Ministry of Health
- Rachel Martens, Imagine Citizen Network
- Wayne Miller, Canadian Patient Safety Institute[5], now Healthcare Excellence Canada

5 In 2021, the Canadian Patient Safety Institute (CPSI) and the Canadian Foundation for Healthcare Improvement (CFHI) came together for form a new organization, Healthcare Excellence Canada (HEC).

# APPENDIX B: Interview and Focus Group Demographics

Patient and Care Partner Interview and Focus Group Demographics (N=28)

(Note: Demographics were not collected for the healthcare provider cohort and World Café)

| Role | Patient | Care Partner | Both a Patient and Care Partner |
|---|---|---|---|
| Gender | Female: 9<br>Male: 5 | Female: 6<br>Male: 3 | Female: 5<br>Male: 0 |
| Age | 18 to 39: 2<br>40 to 64: 8<br>65 to 85: 3<br>No response: 1 | 18 to 39: 1<br>40 to 64: 6<br>65 to 85: 2 | 18 to 39: 1<br>40 to 64: 2<br>65 to 85: 2 |
| Education Level | < High School: 2<br>Post-Secondary: 5<br>Trade/Certificate/Diploma: 3<br>Graduate: 3<br>No response: 1 | < High School: 1<br>Post-Secondary: 5<br>Trade/ Certificate/Diploma: 1<br>Graduate: 2 | Post-Secondary: 1<br>Graduate: 2 |
| Length in Current Role (Years) | 1 to 9 years: 3<br>10 to 20 years: 2<br>21 to 40 years: 6<br>Since Childhood: 1<br>No response: 2 | 1 to 9 years: 1<br>10 to 20 years: 4<br>21 plus years: 3<br>No response: 1 | 1 to 9 years: 3<br>10 to 20 years: 2<br>21 plus years: 0 |
| Difficulty making ends meet | Never: 7<br>Sometimes: 5<br>Always: 2 | Never: 6<br>Sometimes: 1<br>Usually: 2 | Never: 4<br>Sometimes: 0<br>Always: 1 |

# APPENDIX C: Actions for Improving our Approach to Past Harm

## Action: Provide patients and care partners opportunities and environments to speak up or report about harm

- Co-create with patients on how to have conversations about harm. Questions that can be used during bedside reporting, leadership rounds, and safety huddles include:

  > Tell me about anything that alarmed or worried you in the past 24 hours?
  >
  > Tell me about harm you have you experienced or witnessed in the past 24 hours?
  >
  > What has made you feel unsafe in the past 24 hours (or since we last talked)?

- Work with staff to help expand their understanding of the different types of harm
- Have dedicated space/office/computer where patients can report harm
- Keep a record of harms, identified by patients and their care partners
- Provide public-facing incident reporting systems

## Action: Disclose, learn from, and follow-up after harm

- Disclose patient safety incidents to patients/care partners
- Provide opportunity for patients and care partners to debrief/seek closure and explore next steps
- Engage patients in safety event analysis/risk management teams
- Co-create solutions with patients and care partners (on how to disclose and have ongoing conversations)
- Use communication tools such as Situation Background Action Response (SBAR) (CPSI, n.d.) to enhance communication between staff and patients after harm occurs
- Have a clear outline of steps after a safety event or issue so patients and care partners know what to expect and when to expect it
- Standardize how to disclose errors honestly and respectfully, tailoring approach to different scenarios
- "Looping back" to patients and care partners to tell them how the issue at hand was addressed

## Action: Use patient advocate to support patients and care partners when harm occurs

- Have access to ombudsperson when they are available/can be contacted when harm occurs
- Have advocates, negotiators, and mediators to support patients and care partners when harm occurs (support should include how to navigate restorative justice system)

## Action: Make data more widely available

- Show data/stats related to harm, patient safety incidents, patient reported safety concerns

# APPENDIX D: Actions for Improving our Approach to Reliability

## Action: Optimize patient-provider partnerships

- Listen and learn from patients and acknowledge them as experts in their care
- Establish joint expectations and revise as required
- Offer a patient advocate in the absence of a care partner
- Use communication tools (e.g., whiteboard) to communicate to the healthcare team, patient's preferences that need to be consistently performed
- Encourage patients to keep a personal record of critical health information to communicate to the healthcare team
- Include patient and care partners in care and teach them about processes, procedures and use of equipment and technology critical to care and safety based on their readiness to participate
- Utilize communication tools such as pamphlets, posters, electronic bulletins to encourage patient-provider partnership and educate about safety critical processes
- Advise patients of changes in healthcare services in context of COVID-19 or other emergency responses

## Action: Learn about patients, perform regular check-ins, optimize communication during transitions in care

- Review patient record and referral documents before care interactions
- Perform safety checks (leverage volunteers, care partners, and patient advocates)
- Provide written instructions, check lists, etc. during transition in care
- Communicate to patients on who to contact if they have concerns / questions during care transitions

**Action: Provide patients and care partners the opportunity and environments to speak up about failures of equipment, tasks, processes, interventions, and pathways**

- Capture patient and care partners concerns and process improvement ideas, using a variety of feedback mechanisms such as.

  online or in-person surveys or interviews

  bedside reporting/rounding

  leadership rounds and listening sessions with patients and care partners

  regular huddles to capture their concerns and process improvement ideas

  patient / care partner / family conferences

- Co-create with patients on how to have conversations about safety related to reliability; conversations can occur during bedside reporting, leadership rounds, and safety huddles
- Have dedicated space/office/computer where patients can report a concern
- Keep a 'tracking record' of reliability issues, and potential solutions identified by providers, patients, and their care partners
- Have a process in place to respond to patients and care partners concerns and follow-up

**Action: Make data more widely available**

- Make it easy for patients to access their test results/health information
- Be transparent and share data with your staff, patients and care partners related to the reliability of processes that are critical to patient safety

# APPENDIX E: Actions for Improving our Approach to Sensitivity to Operations

**Action: Create structures and processes to support patients and care partners to observe, listen, perceive, and speak up about safety and concerns with staff**

- Regularly engage with patients and care partners as core members of the care team
- Co-create with patients, tips and tools on how to have conversations about safety
- Obtain daily feedback from patients and care partners about their perception of safety
- Include patients and care partners in safety conversations such as:
  - bedside reporting/rounding
  - leadership rounds and listening sessions with patients and care partners
  - regular huddles to capture their concerns and process improvement ideas
  - family conferences
  - safety care plans
- Include questions about safety during bedside reporting, leadership rounds, and safety huddles such as:
  - What makes you feel safe?
  - What would make you feel safer?
  - What makes you feel unsafe?
- Create a phone number for patients and care partners to report urgent safety concerns (e.g., Stop the Line) (Bell & Martinez, 2018)
- Provide opportunities for patients to co-create safety solutions with staff
- Have a process in place to act on and close the loop with patient and care partners regarding their safety concerns
- Be sensitive to individual needs – language, culture, social factors

## Action: Optimize communication between patients and providers

- Listen and acknowledge patients as experts in their care
- Listen actively and respond to patients and care partners
  - listen and validate concerns
  - be timely and responsive to concerns and safety requests
  - follow up on needs/concerns
- Create and use tools to help patients and care partners engage in their care considering language barriers, health literacy, and accessibility. Some suggested tools include:
  - a list of specific questions to ask
  - a template for patients to fill out to share their health journey
  - patient bedside whiteboard
- Support patients and care partners when making healthcare decisions and navigating through difficult or complex health issues
- Demonstrate sensitivity to a situation by explaining why an activity or treatment is being done
- Use a variety of feedback mechanisms. These should include informal communication channels such as daily conversations, and formal mechanisms such as surveys, interviews, and focus groups
- Ensure patients are aware of how to contact their clinician, nurse, liaison, patient advocate

## Action: Create environments in which staff feel safe to speak up and feel empowered to intervene

- Create structures and processes where teams, managers, and leaders can speak honestly about their ability to deliver safe, harm-free care each day (possible examples of concerns team members may want to discuss include staffing, patient acuity, patient volume, floating to an unfamiliar unit, etc.)

## Action: Build awareness and communicate the value of patients partnering with providers for patient safety

- Educate patients and care partners on the MMSF (providing a broader lens to safety)
- Provide educational leaflets, videos, and sessions to patients and care partners on involving them in patient safety and improving awareness about the value they bring to creating safety
- Offer staff education and training on how to communicate with patients and care partners about safety
- Offer staff training on cultural safety (e.g., beliefs, values, customs, and expectations)
- Share and and celebrate successes with patients and care partners

## Action: Identify patient advocate and clinical point person

- Offer a patient advocate (negotiator/ mediator) in the absence of a care partner
- Designate a point person, such as their most responsible provider or another clinician

# APPENDIX F: Actions for Improving our Approach to Anticipation and Preparedness

## Action: Create structures and processes to support organizations, staff, patients, and care partners to think ahead, make plans and be prepared

- Ensure safety conversations with patients, care partners and staff include a designated time and space to reflect, be inquisitive, think ahead, plan, and respond to future safety needs
- Offer education and have available tips and tools co-created with patients on the importance of thinking ahead, envisioning possible problems and how to communicate concerns to staff
- Create structures and processes where teams, managers and leaders can speak honestly about identified future risks and collaborate on ways to mitigate risks
- Have systems in place to 'flag' patients that are at risk and communicate mitigating strategies to the patient, care partner and healthcare team
- Gather patient and care partner's input into system and tool design

## Action: Optimize communication between patients, care partners and providers to support thinking ahead, making plans, being prepared, and communicating identified concerns and risks

- Actively communicate with your patients about potential risks associated with healthcare, encourage them to be active partners in monitoring and mitigating harm
- Support patients and care partners with information so they can anticipate what is coming, assess risks and benefits and make informed healthcare decisions
- Help patients to anticipate and prepare by explaining activities or treatment in advance
- Communicate and co-plan discharge instructions and follow-up care in advance so patients and care partners have time to plan and prepare
- Inquire with patients regarding their care preferences (e.g., what matters to them, their right to live at risk, what would make them feel safer)
- Create a phone number for patients and care partners to report urgent safety concerns [e.g., Stop the Line] (Bell & Martinez, 2018)

## Action: Leverage the role of patient advocate and clinical point person to support thinking ahead, making plans, and being prepared

- Ensure patients are aware of how to contact their clinician, nurse, liaison, and/or patient advocate
- Remind patients of the importance of having a patient advocate (negotiator/ mediator) and their role to assist in identifying possible hazards and planning for future healthcare needs
- Accept and advocate for patients' preferences and their right to live at risk. Plan with patients how to best deliver care while still respecting their wishes. Document and communicate the plan with the healthcare team

## Action: Build awareness and communicate with patients about potential for harm in healthcare

- Provide educational leaflets, videos, and sessions to patients and care partners on involving them in patient safety and improving awareness about safety and harm
- Inform patients on risks inherent in care being delivered (specific to the sector/unit)
- Leverage stories – audio, video, and written stories to help illustrate risks associated with healthcare

# APPENDIX G: Actions for Improving our Approach to Integration and Learning

## Action: Support patients and care partners in gathering, integrating, learning, and responding to information

- Create environments to support patients and their care partners in being active participants in safe care across all five domains of the MMSF
- Support patient/provider partnership to collect, integrate, learn from and act on safety information gathered from past harm, reliability, sensitivity to operations, and anticipation and preparedness
- Use advocates to support communication between patients, care partners and staff

## Action: Support patients and care partners with their own integration and learning by enabling access to and ownership of information

- Provide patients and the care team access to the patients' medical records in real time
- Provide a translator to ensure health information is relayed to the patient in their preferred language
- Assist patients and care partners to interpret their health information and respond to their questions
- Have access to health information in various formats such as paper, online, and white board at the bedside
- Inquire with patient's their preference regarding how much information they would like to have access to avoid the risk of information overload
- Normalize the culture around access to information as a patient right (through education and training and provider behaviors such as asking patients if they want access)