

# Public Reporting; Is it Making a Difference

A presentation to the South Eastern Ontario  
Infection Control Networks Conference for  
Health Service Provider Leaders

September 25, 2009



## Patient Safety - Impetus for the change

- Patient safety has been highlighted with the release of various study results demonstrating the prevalence of preventable adverse events in health care.
- The government announced public reporting of eight indicators on May 28, 2008.
- The patient safety initiative has proven a major success in its first year.

## Innovation

- A ministry cross-functional team was established to develop and implement the structure and scope of the patient safety initiative.
- Developed – for the first time ever in Ontario – standardized data elements, case definitions, and reporting requirements
  - Ontario can now establish baselines that can be tracked and used for comparative analysis.
- Established definitions for CDAD outbreak and processes for hospitals that were experiencing these outbreaks.
- Involved close cooperation with the Ontario Hospital Association throughout the entire process, which led to high hospital engagement and the formation of the program.
- Ontario now has the most comprehensive patient safety public reporting regime in North America.

3

## The Indicators

Indicators	Public reporting
1. Clostridium difficile associated disease (CDAD)	September 26, 2008
2. Methillin resistant staphylococcus aureus (MRSA)	December 30, 2008
3. Vancomycin-resistant Enterococcus (VRE)	December 30, 2008
4. CIHI's Hospital standardized mortality ratio (HSMR)	December 30, 2008
5. Hand hygiene compliance	April 30, 2009
6. Central Line infection (CLI) in ICU	April 30, 2009
7. Ventilator associated pneumonia (VAP) in ICU	April 30, 2009
8. Surgical site infection prevention (SSI-PRV)	April 30, 2009

4

## How It Was Done

- Integration of existing patient safety initiatives:
  - Just Clean Your Hands – launched in March 2008.
  - Fourteen Regional Infection Control Networks (RICNs).
  - Coordination of case definitions with Safer Healthcare Now!
- Integration of government Health Human Resource objectives:
  - Provided funding for an additional 166 infection prevention and control practitioners, and
  - Created Infection Control Resource Teams (ICRTs)
- Integration of IT infrastructure:
  - Adapted an existing web reporting tool already used by hospitals for ministry submissions
  - Convergence with Critical Care Information System for one system to support additional need
- Education:
  - The team led information/training sessions for all hospitals, public health staff, and 14 Regional Infection Control Networks (RICNs).
- Regulation enacted to require hospital public reporting.

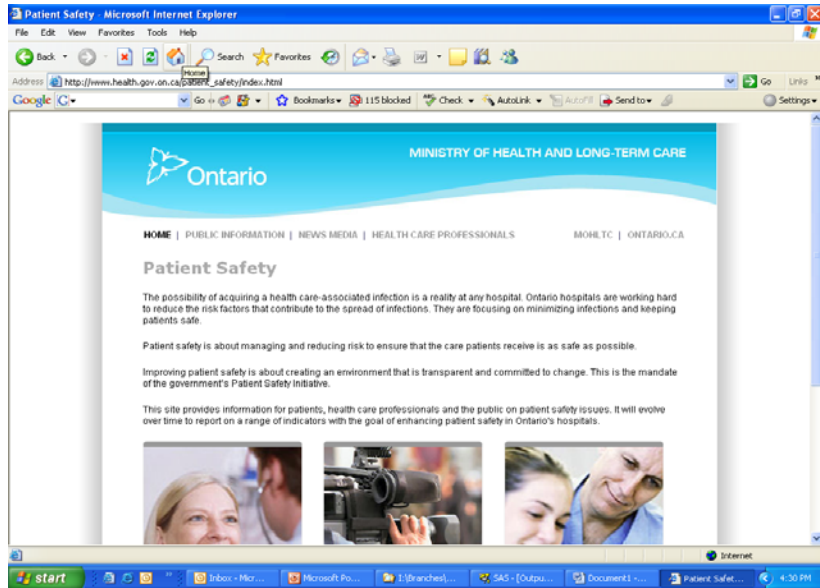
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## How It Was Done

- Media Relations
  - The ministry established a panel of leading experts to speak to this issue and provide factual balance
  - A media campaign was launched in July, 2008 that approached key health media and provided them with individual, in-depth media interviews with the expert panel.
  - Media briefings were conducted across Ontario
  - Each time new indicators are launched media are briefed
- Web Site
  - A comprehensive web site was created that showcases the patient safety indicator rates and also provides accurate and relevant information

6

## How It Was Done: Patient Safety Website



## How It Was Done: Patient Safety Website

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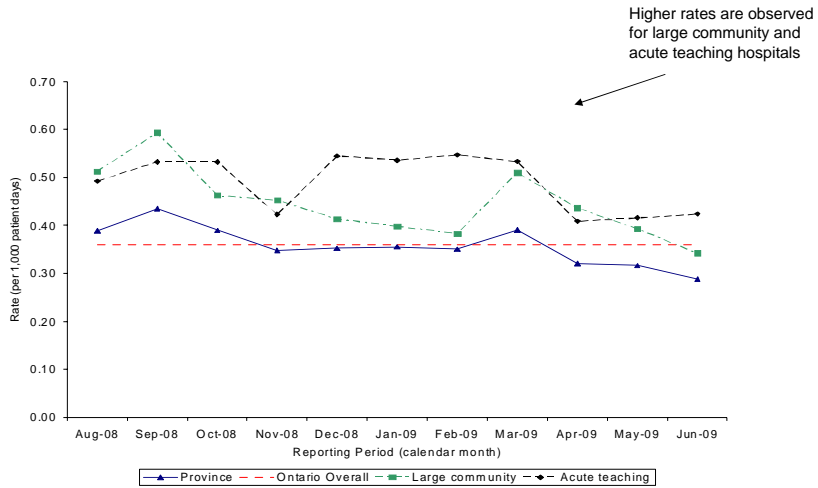
Patient Safety Indicator Reporting: Search Results

**Scarborough General Hospital** [View Hospital Website](#)  
[View Provincial Summary](#)

Indicator	Reporting Period	Data	
Clostridium Difficile Associated Disease (CDAD)	Mar 01 - Mar 31, 2009	Rate per 1,000 patient days: 0.31 Case Count: <= 5	Compare with similar hospitals
Methicillin Resistant Staphylococcus Aureus (MRSA)	Jan 01 - Mar 31, 2009	Rate per 1,000 patient days: 0.00 Case Count: 0	Compare with similar hospitals
Vancomycin Resistant Enterococcus (VRE)	Jan 01 - Mar 31, 2009	Rate per 1,000 patient days: 0.00 Case Count: 0	Compare with similar hospitals
Hospital Standardized Mortality Ratio (HSMR)	Apr 01, 2007 - Mar 31, 2008	Canadian Institute for Health Information (CIHI) HSMR reports	CIHI reports HSMR data for eligible acute care hospitals only
Central-Line Primary Blood Stream Infection (CLI)	Jan 01 - Mar 31, 2009	Rate per 1,000 central line days: 0.00 Case Count: 0	Compare with similar hospitals
Ventilator-Associated Pneumonia (VAP)	Jan 01 - Mar 31, 2009	Rate per 1,000 ventilator days: 0.00 Case Count: 0	Compare with similar hospitals
Surgical Site Infection Prevention	Jan 01 - Mar 31, 2009	Percent (%): 97.59 Case Count: -	Compare with similar hospitals
Hand Hygiene Compliance	Apr 01, 2008 - Mar 31, 2009	Compliance before patient contact (%): 93.00 Compliance after patient contact (%): 97.00	Compare with similar hospitals

If you experience difficulties or need further assistance, please contact us.

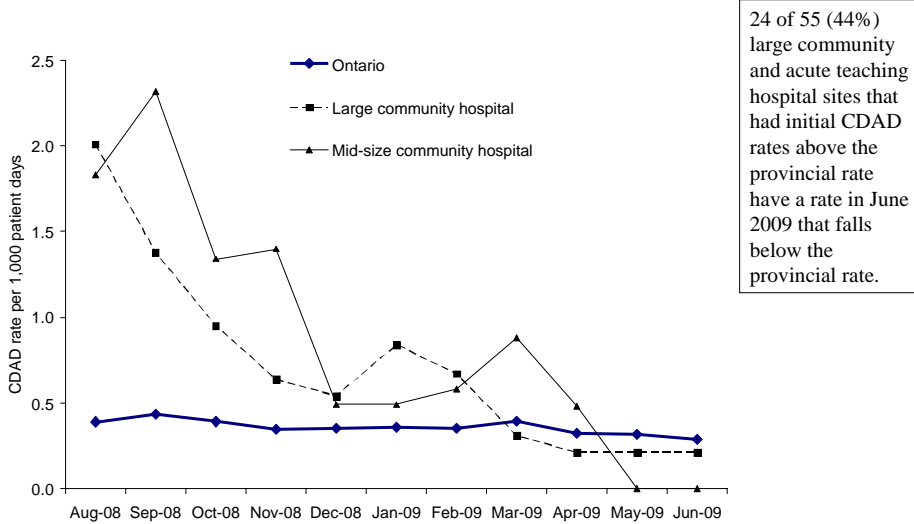
**CDAD rates have been consistent showing a small decline since reporting began**



• Ontario's rates compare favorably to those in other jurisdictions

9

**Hospitals are making improvements to their CDAD Rates**



24 of 55 (44%) large community and acute teaching hospital sites that had initial CDAD rates above the provincial rate have a rate in June 2009 that falls below the provincial rate.

10

## Results achieved to date

- The patient safety initiative has succeeded in leading the country in transparency by reporting patient safety indicators to Ontarians.
- Resulted in more hospitals using this information to adopt appropriate measures to improve infection prevention and control.
  - A 2006 study showed the hand hygiene compliance rate in selected Ontario hospitals to be 32%. In April 2009 Ontario hospitals reported a hand hygiene compliance rate of 62%.
- Ontario's public safety indicators compare favourably to other jurisdictions. In many cases there are no comparable jurisdictions because Ontario is a leader in this area.

11

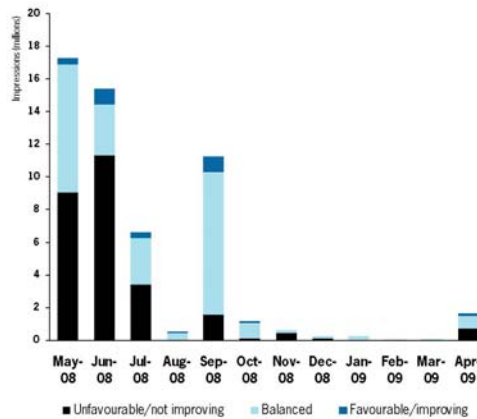
## Results achieved: Ontario compares favorably to all other reporting jurisdictions

Indicators	Other jurisdictions publicly reporting
Clostridium difficile associated disease (CDAD)	Quebec, UK
Methillin resistant staphylococcus aureus (MRSA)	Australia, UK
Central Line infection (CLI) in ICU	Australia, Various US states
Ventilator associated pneumonia (VAP) in ICU	Various US states
Surgical site infection prevention (SSI-PRV)	Various US states
CIHI's Hospital standardized mortality ratio (HSMR)	UK
Hand hygiene compliance	No Others Reporting
Vancomycin-resistant Enterococcus (VRE)	No Others Reporting

12

## Results Achieved: Media Coverage – Tone improves with public reporting

- Critical coverage was over 2/3 of total media exposure when CDAD was first reported.
- Negative coverage of CDAD continued in July representing 50% of total exposure.
- By September the tone improved with negative exposure down to less than 10% of total exposure.



Source: CORMEX Research Media Analysis

13

## Hand hygiene compliance

**Before patient contact**

**After patient contact**

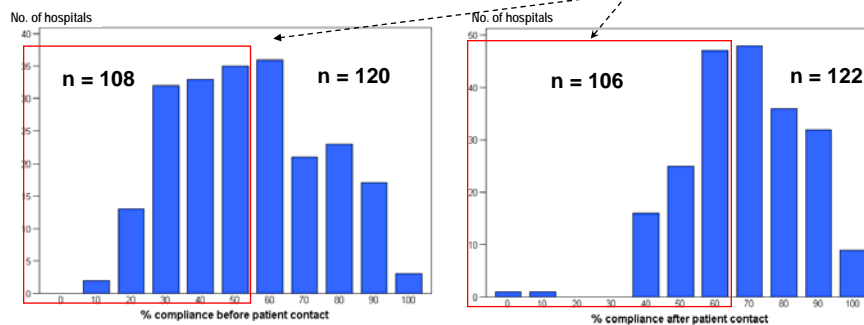
*Overall compliance in Ontario:*

53%

69%

*Hospital level performance:*

Room for improvement




14

# Surgical Safety Checklist

- In February the Minister directed the MOHLTC to work on a surgical safety checklist.
- The checklist provides a list of the most common tasks and items that operating room teams carry out in the perioperative period to ensure patient safety.
- It was developed as a tool to support patient care through good preparation and teamwork.
- The consistent use of the checklist has been shown to reduce rates of death and complications associated with surgical care.

15



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**BRIEFING – Before induction of anesthesia**

*Hand-off from ER, Nursing Unit or ICU*

- Anesthesia equipment safety check completed
- Patient information confirmed
  - Identity (2 identifiers)
  - Consent(s)
  - Site and procedure
  - Site, side and level marked
  - Clinical documentation
  - History, physical, labs, biopsy and x-rays
- Review final test results
- Confirm essential imaging displayed
- ASA Class
- Allergies
- Medications
  - Antibiotic prophylaxis: double dose?
  - Glycemic control
  - Beta blockers
  - Anticoagulant therapy (e.g., Warfarin)?
- VTE Prophylaxis
  - Anticoagulant
  - Mechanical
- Difficult Airway / Aspiration Risk
  - Confirm equipment and assistance available
- Monitoring
  - Pulse oximetry, ECG, BP, arterial line, CVP, temperature and urine catheter
- Blood loss
  - Anticipated to be more than 500 ml (adult) or more than 7 ml/kg (child)
  - Blood products required and available
  - Patient grouped, screened and cross matched

**BRIEFING (continued)**

- Surgeon(s) review(s)
  - Specific patient concerns, critical steps, and special instruments or implants
- Anesthesiologist(s) review(s)
  - Specific patient concerns and critical resuscitation plans
- Nurses(s) review(s)
  - Specific patient concerns, sterility indicator results and equipment / implant issues
- Patient positioning and support / Warming devices
- Special precautions
- Expected procedure time / Postoperative destination

**TIME OUT – Before skin incision**

- All team members introduce themselves by name and role
- Surgeon, Anesthesiologist, and Nurse verbally confirm
  - Patient
  - Site, side and level
  - Procedure
  - Antibiotic prophylaxis: repeat dose?
  - Final optimal positioning of patient
- "Does anyone have any other questions or concerns before proceeding?"

**DEBRIEFING – Before patient leaves OR**

- Surgeon reviews with entire team
  - Procedure
  - Important intra-operative events
  - Fluid balance / management
- Anesthesiologist reviews with entire team
  - Important intra-operative events
  - Recovery plans (including postoperative ventilation, pain management, glucose and temperature)
- Nurse(s) review(s) with entire team
  - Instrument / sponge / needle counts
  - Specimen labelling and management
  - Important intraoperative events (including equipment malfunction)
- Changes to post-operative destination?
- What are the KEY concerns for this patient's recovery and management?
- Could anything have been done to make this case safer or more efficient?

*Hand-off to PACU / RR, Nursing Unit or ICU*

**PATIENT INFORMATION**

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Adapted from the WHO Surgical Safety Checklist. © World Health Organization, 2008

Surgical Safety Checklist: Canada  
Version 1, January 9, 2009

16

## Surgical Safety Checklist – Stakeholder Consultation and Feedback

- On June 19<sup>th</sup> surgical experts (surgeons, anesthesiologist, OR nurses, OR managers, etc.) were consulted.
- Experts provided advice on the province wide implementation of the checklist by identifying key requirements for the successful implementation of the checklist and public reporting on compliance.
- Based on the advice provided, a plan for successful implementation of the checklist and public reporting has been developed.

17

## Surgical Safety Checklist – Indicator

### Case Definition

- The percent of surgeries in which the CPSI surgical safety checklist was performed.
- The surgical checklist is considered performed when the designated checklist coordinator confirms that the surgical team members have addressed all of the necessary tasks and items in each of the three surgical phases – briefing, time out, and debriefing.

18

## Surgical Safety Checklist - Indicator

- **Method of calculation:**

$$\frac{\text{Total \# of times all three phases of the checklist was performed}}{\text{Total Surgeries}} \times 100 = \% \text{ Compliance}$$

- All surgical procedures are included.
- Those hospitals that are not part of the SET program or do not have an electronic OR system, may submit an estimated compliance rate based on a sample of surgeries:
  - Minimum sample size is 100 surgeries.
  - Samples should include all types of surgeries performed in the hospital, and a cross-section of operating rooms and surgical teams.
  - Where a facility does not perform 100 surgeries over a 6-month period, then all surgeries should be included for public reporting.

19

## Surgical Safety Checklist - Indicator

### **Reporting:**

- **Timeframe:** Initial July 2010 reporting should include data collected for April 01 to June 30, 2010.
- Reporting will be bi-annually:

Period	Period End Date	MOHLTC Reporting Date	Public Website Reporting Date
1	30-Jun-10	15-Jul-10	31-Jul-10
2	31-Dec-10	15-Jan-11	31-Jan-11

20

## Surgical Safety Checklist - Indicator

### Data Submission:

- Data capture will be done through the SET program for wait time funded hospitals.
  - Covers approximately 90% of all surgeries performed in Ontario and 113 hospital sites.
- Data capture will be done through WERS for all remaining hospitals.

21

## Surgical Checklist – Program Implementation

- To support implementation of the program, the following will be completed in partnership with the OHA by the end of March 2010:
  - Development of a Surgical Checklist Toolkit
  - Development of educational materials
  - Coordination and execution of regional education sessions

22