A presentation to

The Commission to Investigate the Introduction and Spread of SARS in Ontario

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October 1, 2003

Improve PATIENT and HEALTH CARE WORKER SAFETY

- We felt that there is a important opportunity to ***learn*** from SARS and shine a light on issues that we feel would improve the safety of Patients and Health Care Workers.
- Much of Ontario already lags behind the rest of the world in this endeavour.. Yet Ontario could LEAD if we do it well.
- We do NOT advocate a “name, blame, and shame” approach

Health care must become a "High Reliability" System

Prof. James Reason, an internationally renowned Patient Safety expert in his article in the British Medical Journal said:

"High reliability organisations are the prime examples of the system approach. They anticipate the worst and equip themselves to deal with it at all levels of the organisation. …

High reliability organisations are not immune to adverse events, but they have learnt the knack of converting these occasional setbacks into enhanced resilience of the system". (Ref: **BMJ** VOLUME 320 18 MARCH 2000)

High reliability

We also need to consider the importance of *culture* in improving the health care system. The current culture in health is not conducive to high reliability management processes.

- Drawing from the traits of high reliability organizations and the science that has already been established in this realm, this Commission should begin by insisting on a review process which involves systemic elements including:
  - People,
  - Procedures,
  - Hardware/Facilities and,
  - the Managed Environment.

We NEED Admin AND Clinical

- Traditional: for many in health care it appears that clinical and administrative approaches to the decision making shouldn't be mixed
  - separation of administration and technical content has been identified as a root cause in both the Challenger and Columbia accidents
  - Administrative decisions cannot be allowed to be taken by administrators that unknowingly intrude on the culture of safety that is necessary at all points of interaction with PATIENTS.
  - Basics: Optimizing cost of healthcare. The public has never seen physician payments tallied along with hospital expenditures. How can you ever know what investment creates the best outcome?

Example of Clinical/Admin Disconnect

A decision was made to have central clearance for all provincial ambulance transfers between hospitals.

- it was directed that each facility needed to have a responsible infection control (IC) staff locally evaluate all patients prior to transfer and receive central approval
- hospitals barely had adequate capacity to deal with IC on a daily routine basis, (a latent problem)
- Clearly it was heard in our daily teleconferences that Front line staff (doctors, nurses, ambulance teams) were left not knowing if their usual clinical responsibilities were eclipsed?

- It raises questions such as: In addition to the known fatalities directly from SARS, were there deaths or significant morbidity associated from delays in other activities?

Additional Resources to Assist in Understanding

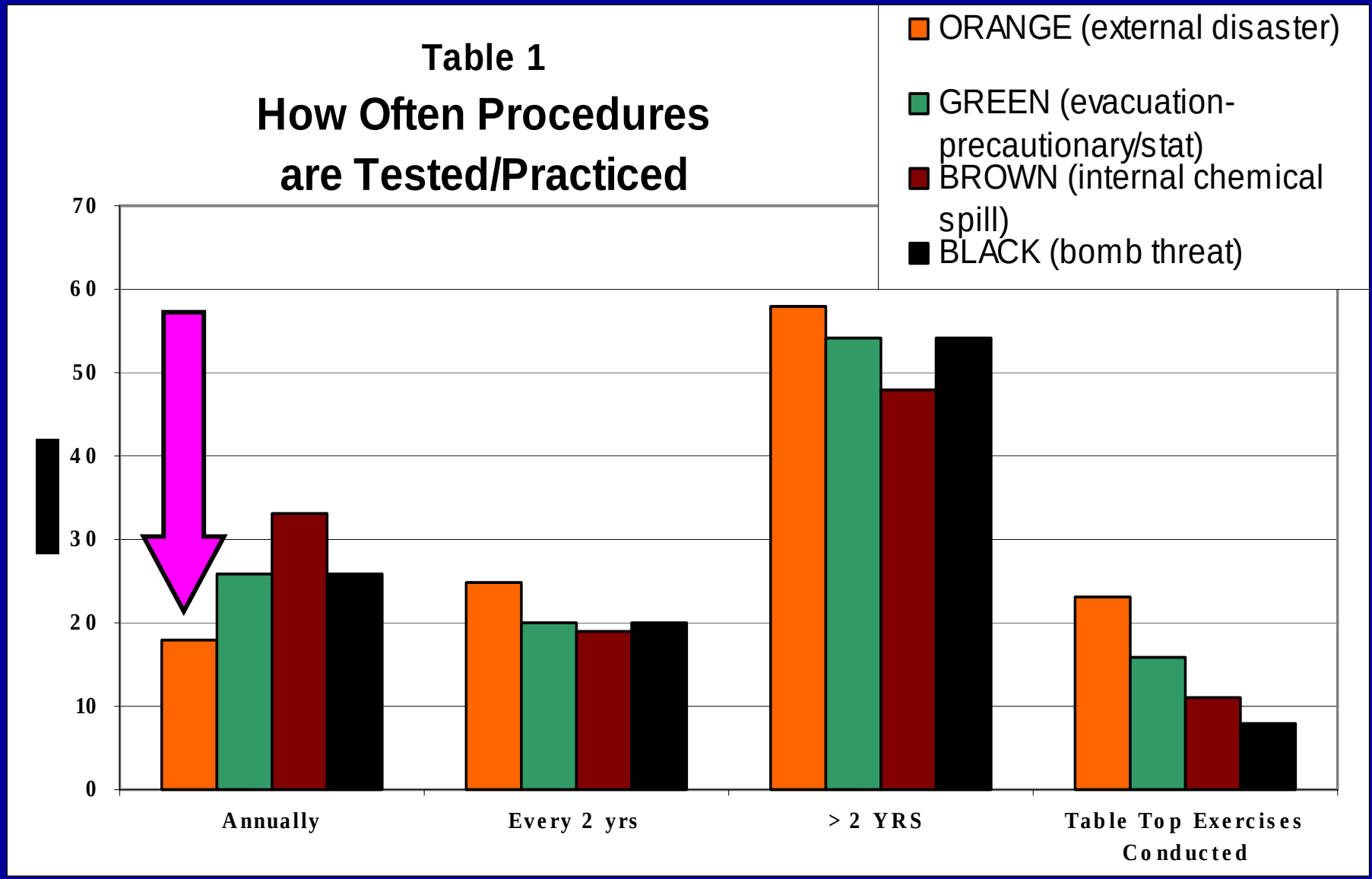
- **OHA's taped SARS teleconferences March-May 2003**

  SARS equivalent of "cockpit flight recordings"

- **OHA's Ontario Hospital Emergency Preparedness Report**

"Responding to Large-Scale Emergencies and Bio-Terrorist Threats" Colin T. Millar March 2002

Prepared?



"Responding to Large-Scale Emergencies and Bio-Terrorist Threats" Colin T. Millar March 2002

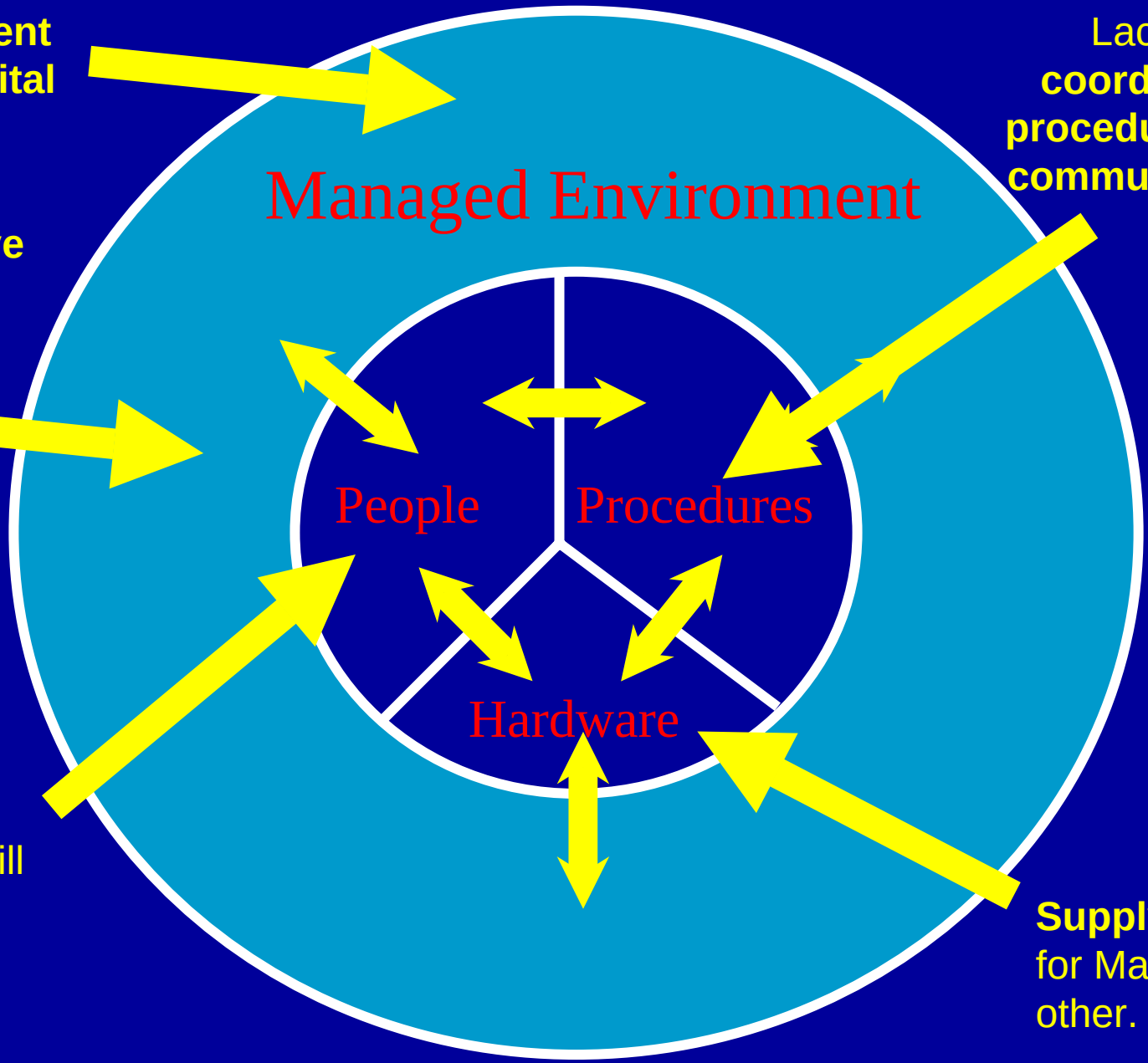
High Level Preparedness Plans not developed/practiced

Government and Hospital Roles

Clinical and Administrative components not integrated

Front Line:

Over reliance on the good will of people



Lack of **coordinated procedures and communication**

Supply chain for Masks and other.

Summary

1. Role of government and hospitals should change fundamentally
2. Increase hospital *systemic* planning
3. Open the *Public Hospitals Act*
4. Leadership: Doing it! Not just drawing attention to problems
5. Emergency plans AND *practice*
6. Actively engage front line staff and end the disenfranchising practices

Thank you

Additional materials

High Level Preparedness

- Common features:
  - The SARS outbreak,
  - the Ontario hospital response to “9 – 11” and
  - periodic emergency room crises
- It is evident that systemic emergency plans were and are both underdeveloped and insufficiently practiced.
- While many individuals held the system together and improvised, it would be wrong to feel that they will be able to continue to carry us through system emergencies in future.

Government Role

- Successive Ontario Governments have been determining system needs by intuitively responding to short-term pressures rather than using normal managerial tools and timeframes, therefore eroding the hospital system – in terms of morale, skills, equipment and capacity
  - Until recently, for example, the province had no consolidation of hospital's individual finances to determine system needs,
  - nor did it have a clear understanding of the systemic output of the hospital system or the consumer response to it.
  - budgets are never known in advance of the fiscal year with the result that all planning –emergency or otherwise- is fundamentally impaired

Hospital Role

- Hospitals themselves have not played the role they should play on the system emergency issue.
- The ability of the system and individual hospitals to respond quickly in an emergency is hindered by a governance and leadership culture which is out of phase with the pace of events on the front lines and by a wholly inappropriate tendency to “pass the buck” for system leadership to governments.
- Governments could legitimately expect to be advised that system emergency plans exist, are being practiced and that everyone concerned in institutions knows in advance how such emergencies will be managed.
- Additionally, the interfaces between hospitals and other agencies such as ambulance, fire, and police must be optimized for both day-to-day activities of patient care, but particularly for emergency scenario planning.

The Front Line

Excessive presumption and reliance on the ongoing goodwill and capabilities of front line staff.

- planning in our system is done for the average, not the peak demand and such deficits are expected to be made up by staff
  - working harder and longer,
  - inserting casual staff who may not be familiar with protocols/systems, or
  - lowering the standards of patient care.

This has implications for both the SARS specific events but for general day-to-day management as well.

Lack of Systemic Coordination

- system co-ordination and understanding is insufficient on matters relating to procedures (e.g. mask fitting) and on inventories of supplies. (e.g. masks, gloves, cleaning solutions)
- All hospitals should be on the same supply chain management system so that every hospital and clinician can immediately understand the supply situation of the whole system.
- a common set of clinical pathways should also be in place covering most common illnesses in hospitals. It is little wonder that such variability exists when the systemic tools to facilitate such processes are lacking
- There must be a systematic communication system that works! And is tested from time to time to ensure it does.

What Should NOT be Done

- ***Assume SARS was a "One off"***
- ***Simply increase funding to the existing system and assume we will be fine***
- ***Continue to rely on a leaderless model that diffuses responsibility***

What Should be Done

- Firstly this Commission will set an example if it uses techniques such as:
  - Events and Conditions Charting to describe what happened,
  - Root Cause Analysis to find proximal causes for the major events as they unfolded, and
  - Failure Modes and Effects Analysis to identify key vulnerabilities in any proposed systemic changes

What Should be Done

Modernize the governance structure of the hospital system and open the Public Hospitals Act:

- demanding much more system planning,
- by formalizing access by the workforce to decision makers and
- by shifting the role of the Ministry to purchasing services from institutions rather than intruding in virtually every aspect of their operations and thereby diffusing responsibility.
- Included in this process MUST be a strong leadership commitment to high reliability and patient safety and a culture that supports it.

What Should be Done

- Get the day to day fiscal and managerial planning up to a basic standard using the everyday tools for such activities in place in the private and large parts of the public sectors. Report results in a transparent and comparable (to other business) format.

What Should be Done

- On the specific matter of emergency preparedness, set a specific date by which a systemic emergency plan will be developed by hospitals and both put in place and practiced. They would need much outside help and advice to do this well and probably significant targeted funding as well.

What Should be Done

- Engage front line staff and certainly professional Colleges, Associations and Unions in upgrading our response to emergencies
- Clearly stipulate responsibilities for action and decision making