Executive Summary **Jaime C. Pinilla M.D.**

Detection of Adverse Events and Minimization of Harm in Critically Ill Patients: Royal University Hospital. Intensive Care Unit. Saskatoon Health Region.

The development of reliable methods for the detection and prevention of adverse events is paramount to enhancing safety. Proactive methods must be developed to detect high risk situations and to "build in" safety and quality throughout all processes of care. Royal University Hospital Intensive care Unit innovative approach to improvement the detection and control of adverse events has enabled us to increase quality and safety of critically ill patients and contribute to Saskatoon Health Region Care's strategic growth.

Recognized opportunities for improvement led to the following goals.

Harm produced by preventable adverse events

- 93% of all adverse events produced no harm or temporary (reversible) harm
- 4% of adverse events resulted in a prolonged ICU stay
- In 0.1% (1 patient) an adverse event resulted in death

Care delivery related to preventable adverse events

- 85% of adverse events in all cases were resolved by applying best practice within 24 hours
- 15% of adverse events were unresolved
- In 87% of those suffering adverse events the care delivered was inappropriate (did not follow best standard of practice)

Mortality Categorization

- 1% of all deaths were preventable prior to ICU admission
- 9.5% of deaths were potentially preventable prior to ICU admission
- During the ICU stay all deaths were categorized as non-preventable

Culture of Safety Survey

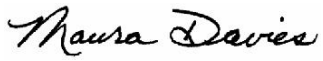
This survey demonstrated that

- 68.3% felt positively about organizational learning and continuous improvement in relation to the ICU program.
- 81.7% felt positively about the teamwork occurring as a result of initiatives.
- 70% of staff felt positively about the openness of communication within the ICU.
- 48.3% felt that reporting was non-punitive, illustrating the continued need to reinforce a "blame free" environment.

The ICU Quality Improvement Program has demonstrated positive results which have proven to be sustainable. A culture of safety and improvement has been achieved within the unit. Daily data collection during clinical rounds allows for prompt intervention and correction of adverse events. Bimonthly Quality Improvement Rounds provide a forum for planning and action to prevent reoccurrence.

The ICU Quality Improvement Program and adverse event reduction initiative provides an example of a successful process for enhancing patient safety which may be adapted for use in other clinical settings and on an organization-wide basis.

We have been successful fostering a culture of safety and we believe that our initiative should be considered for the 3 M award.



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