Patients:
A Vital Part of the Healthcare Team
Speak Up! & Listen Up!

Cleveland Clinic
Patient Experience Summit
May 21st 2014

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Outline

• Context
  – JGH
  – Québec context

• Our initiatives
  – Transformational change at the JGH
  – Board of Directors
  – Committees of the Board

• Results
  – Revised Code of Ethics
  – Patient’s Bill of Rights
  – Disclosure training / pamphlets
  – Sentinel Event Review Champion
  – Speak-up! Campaign
  – Learning from our mistakes

Lessons learned & discussion
April 1, 2012 - March 31, 2013

Beds: 637
Total staff: 4,869
Attending doctors: 645
Medical residents: 188 / 636
Total nurses: 1,441
Total student nurses trained: 650
Total volunteers: More than 1,000

Admissions (including newborns): 24,800
Patient days (including newborns): 205,947
Babies delivered: 4,500
Outpatient visits: 572,000
Emergency visits: 67,000
Prescriptions processed: 622,868
Legislative changes within Quebec

Bill 113 (2002, S-4.2 chapter 71)
An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services.

Obligation to:
- Report adverse events (incidents and accidents)
- Risk Management Committee (corrective & preventive measures)
- Central registry for adverse events
- Local risk management committee and process
- Disclosure requirement (include preventive & support measures)
- Accreditation requirement
Legislative changes within Quebec

Bill 83 (2005, S-4.2 chapter 32)

An Act to amend the act respecting health services and social services and other legislative

Obligation to:

- Create a Watchdog Committee
- Establish a Patient’s Committee for each organization
- Unique role of the Ombudsman
- Board of Directors must include 2 members from the Patient’s Committee
- The Watchdog Committee must include 1 member from the Patient’s Committee
Faculté de médecine

Bureau facultaire de l’expertise patient partenaire

Appuyant la Faculté dans son important virage patient* partenaire, le Bureau propose d’évoluer vers une nouvelle vision collaborative où patients et professionnels de la santé redéfinissent le cœur de leur relation afin de faire face ensemble aux défis de demain.

Relevant directement du vice-décanat exécutif, le Bureau assure ainsi la promotion et la représentation du patient au sein de la Faculté de médecine. Il joue un rôle conseil auprès des membres du Réseau universitaire intégré de santé de l’Université de Montréal (RUIS de l’UdeM) dans l’accompagnement de plusieurs équipes cliniques sur le terrain dans l’amélioration de leurs pratiques en « partenariat de soins et de services ».

Créé le 12 octobre 2010, le Bureau travaille au développement et déploiement de plusieurs projets porteurs qui visent à faire du patient un partenaire à part entière sur le plan de l’enseignement, de la recherche et des soins de santé. Ces nombreuses initiatives sont actuellement lancées en étroite collaboration avec nos partenaires du RUIS et du Centre de pédagogie appliquée aux sciences de la santé (CPASS) de l’UdeM afin d’assurer que les établissements de soins affiliés à l’Université de Montréal et leurs équipes puissent profiter pleinement de leurs atouts.
Patient Experience Community of Practice

COMMUNAUTÉ DE PRATIQUE EN ÉVALUATION DE L’EXPÉRIENCE PATIENT

DOCUMENT DE PRÉSENTATION

Préparé par le CHU de Québec, le Centre hospitalier universitaire de Sherbrooke (CHUS), le Centre universitaire de santé McGill, le Centre hospitalier universitaire de Montréal (CHUM), le Centre hospitalier universitaire (CHU) Sainte-Justine et l'Hôpital général juif
Why?

- Patients are now asked to become more involved in their own care.
- Health literacy and clear communication are critical to patients staying safe!
- Every patient has the right to receive healthcare instructions and information in a way that they can understand.
An Informed Patient is a Safe Patient

Speak-Up

Your right to know

Informed consent

PFSRC

Concerns about your care

Medication safety

Hand hygiene

Preventing falls

Preventing pressure ulcers

Speak up

JGH patients have certain rights and responsibilities.

Speak up! Ensures patients to:

Speak up! If you have any questions or concerns, it is your right to know.

Pay attention.

Educate yourself about your condition.

Ask a trusted family member or friend to be your supporter while you are in the hospital.

Know which medications you are taking and why you are taking them.

Understand that you are the centre of your healthcare team.

Participate in all decisions about your treatment.

It’s your health!

Your right to know

Any healthcare error that affects your health or results in a change to your care plan must be disclosed to you.

Informed consent

You have the right to be given information on the risks and benefits of the tests and treatments that you are receiving.

You have the right to refuse interventions.

This JGH Patient & Family Resource Centre (PFSRC), located in room A-200 (Pavilion A, Côte-des-Neiges entrance, ext. 2431), can help you to find accurate and up-to-date health information.

Speak-Up/Info

Concerns about your care

If you are not satisfied with your care, you are encouraged to first speak with the person responsible for your care, the head nurse or doctor on call.

You also have access to the hospital ombudsman who can be reached at 842-340-8233, ext. 8433.

For your hospital stay:

Do not bring any valuables.

Bring to the hospital:

- Comfortable shoes
- Eyeglasses
- Dentures
- List of medications

For your outpatient appointments:

- Bring your complete and updated list of medications.
- Prepare a list of questions for your doctor.

Medication safety

When you are admitted to the hospital:

- Bring with you an up-to-date list of all your medications, including herbal supplements and vitamins, or bring the medications in their original containers.
- Always inform your doctor, nurse and pharmacist about your allergies or intolerances to medications.

In the hospital:

- Look at all the medications you receive. If the medications that are given do not look familiar, inform your doctor, nurse or pharmacist.
- When you leave the hospital:

Hand hygiene

Cleanliness and safety go hand in hand.

Why are clean hands important?

Cleaning hands is one of the fastest and best ways to stop the spread of infections.

How should hands be cleaned?

Alcohol-based hand rub or soap and water are the most effective methods of cleaning hands.

When should you clean your hands?

Before and after meals, and after sneezing, coughing or using the washroom.

Who needs clean hands?

Everyone. Visitors should clean their hands before entering and after leaving your room. Don’t hesitate to ask your doctor, nurse or other healthcare provider to clean their hands before touching you.

Preventing falls

The JGH has a fall assessment and prevention policy.

The goal is to reduce falls and injuries in the hospital and at home by developing an individualized care plan. Speak up about fall prevention! You are encouraged to talk to healthcare staff to share information about previous falls and ways to prevent future falls.

You can help reduce your risk of falls. For example:

- Make sure to have non-slip shoes
- Make sure that you wear any vision or hearing aids
- Remember to use your walker or cane if you have one.

Preventing falls is everyone’s responsibility.

Preventing pressure ulcers

What are pressure ulcers?

Pressure ulcers (also known as bed sores) are sores that develop when blood flow to a part of the body is blocked and the tissue in that area dies.

Where do they occur?

- They occur most often over bony areas (e.g., heel, tail bone, hip).

How can they be prevented?

The best way to prevent pressure ulcers is to change position often, eat and drink well, and keep heels free of pressure (use cushions under your calves).
An Informed Patient is a Safe Patient

Offers information and tips for patients to:

• enhance clear communication
• make care a more positive experience
• increase health literacy
• help reduce healthcare errors and sentinel events
Patient’s point of view

• Request timely information in an honest and transparent manner.

• Be considered a member of the healthcare team.

• Be involved in all decisions in their care.

• Be provided with information needed to make informed decisions.
Information Needs – Patient Satisfaction

- The strongest predictor of patient satisfaction is how much information is given to the patient about diagnosis, the causes and course of a disease, or possible treatments and what they entail.

- Patients who receive more information are more satisfied than patients who get less information.

Hall, Roter and Katz, Medical Care 1988: 28: 657-675
Information Needs - Patient Satisfaction

- The nursing staff was prepared to answer my questions about my condition
  Importance: 92%  Satisfaction rate: 84%

- Throughout my hospital stay, the doctor kept me informed about the evolution of my condition
  Importance: 97%  Satisfaction rate: 88%

- I was able to participate in making the decisions I wanted to be involved
  Importance: 94%  Satisfaction rate: 85%

2012-2013 JGH Patient Satisfaction Program
Patient Role

As a member of the Healthcare Team

• Help develop guiding principles
• Ensure patient issues and perspectives are addressed
• Share experiences
• Assist with monitoring
• Identify risks
What can we do?
Communicate Effectively

- Involve patients and families as partners
- Being culturally respectful and knowledgeable
- Use simple language, avoid complex terms
- Communicating honestly about treatment interventions, risks and adverse events
- Permit time for comments and questions
- Address all concerns and questions
Better informed / involved patient

leads to ...

• Increased adherence to treatment
• Improved health literacy
• Optimum use of limited resources
• Better outcomes
• Less errors in their care
JGH Patient Safety Indicators

- Central Line Associated Bloodstream Infections (CLABSI)
- Clostridium Difficile Associated Infections (C-Difficile)
- Methicillin-resistant Staphylococcus aureus (MRSA)
- Catheter Associated Urinary Infections (CAUTI)
- Vancomycin-resistant enterococci (VRE)
- Ventilator Associated Pneumonia (VAP)
- Venous Thromboembolism (VTE)
- Reported Incidents / Accidents
- Medication related Incidents
- Surgical Site Infections (SSI)
- Surgical Safety Check-list
- Pressure Ulcers (PUP)
- Hand Hygiene
- Patient Falls

**Goal:** To include patients as members of all our Quality & Safety Improvement Teams
WWW.JGH.CA/QI

Live on July 13th 2011

Quality Indicators - CEO Message

Why Quality Indicators matter to your health
A message from Dr. Hartley Stern, Executive Director of the JGH

As a patient, you have a right to know about the record of performance of the hospital in which you place your trust. You need this information especially now that patients are taking a more active role in the course of prevention, testing, treatment and care.

For this reason, the Jewish General Hospital has embarked on a program—the first of its kind in
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<tr>
<th>Roll Out Plan</th>
<th>Quality Indicators</th>
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<td><strong>July 2011</strong></td>
<td>Patient Satisfaction – Overall Average Satisfaction Rate</td>
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<td>Ventilator Associated Pneumonia</td>
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<td>Surgical Safety Checklist</td>
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<td><strong>December 2011</strong></td>
<td>Total Reported Incidents and Accidents</td>
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<td><strong>Patient Satisfaction – Areas of higher and lower satisfaction</strong></td>
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<td><strong>June 2012</strong></td>
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<td>Speak-Up! Campaign</td>
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<td><strong>December 2012</strong></td>
<td>Venous Thromboembolism Prevention</td>
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<td><strong>Patient Satisfaction – Would you recommend this hospital to your family and friends?</strong></td>
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<td><strong>March 2014</strong> (proposed)</td>
<td>Medication Reconciliation</td>
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<td><strong>June 2014</strong> (proposed)</td>
<td>Patient Identification</td>
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<td><strong>December 2014</strong> (proposed)</td>
<td><strong>Patient Satisfaction – Rating of the hospital on a 0–10 scale</strong></td>
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<td><strong>December 2015</strong> (proposed)</td>
<td>Hand Hygiene Compliance</td>
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<td>Surgical-site Infections (NSQIP)</td>
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<td><strong>December 2015</strong> (proposed)</td>
<td>Clostridium Difficile (C. diff)</td>
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<td>Methicillin-resistant Staphylococcus Aureus (MRSA)</td>
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<td></td>
<td>Vancomycin-resistant Enterococci (VRE)</td>
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Total Reported Incidents and Accidents

Adverse Events

The Jewish General Hospital (JGH) is strongly committed to reducing the number of adverse events—whether slight or serious—by improving the conditions where the potential for these events may exist.

Although we live in an imperfect world where accidents are bound to happen, it does not mean accepting it—especially in health care, where a seemingly minor oversight might end up having serious consequences.
Learning from our mistakes

In its commitment to improving patient safety, the Jewish General Hospital is concerned not only with healing and health, but with learning whenever an error has taken place or has been narrowly avoided. While every effort is made to prevent mistakes, they remain a regrettable aspect of health care.

In 2004, the Canadian Adverse Events Study found that on average adverse events occurred at a rate of 7.5 per 100 patients admitted to hospitals across the country. In other words, of the 2.5 million Canadian hospital admissions that were studied, approximately 185,000 were associated with an adverse event. Nearly 37 per cent of those events (close to 70,000) could have been prevented.

Another study found that in Quebec, 5.6 per cent of all adult admission—excluding obstetric and psychiatric cases—were associated with an adverse event. Nearly 27 per cent of those events could have been prevented.
Speak Up! and Listen Up!

The Jewish General Hospital (JGH) is strongly committed to improving the experiences of patients and their relatives, and the work environment of staff in the delivery of medical treatment or during other healthcare activities in the hospital.
Bernie Weinstein

- JGH Volunteer – Community Representative since 2003
- Civil Engineer
- 32-year career with Canadian National Railway - Director of Operating & Capital Budgets.
- Bernie is very happily married and has 3 children and 8 grandchildren
- Loves to travel
Bernie Weinstein
Why should patients be a part of the healthcare team

• Perspective
  – It’s my health!

• Perspective
  – Liaison to the community

• Perspective
  – Incremental, useful resources
How did I get Involved

The story of Claire Freedman: a medication incident
The Quality & Risk Management Committee

Mandate

• Encourage all employees to focus on outcomes of patient care and service delivery, with an emphasis on outcomes related to patient safety
• Promote evidence-based best practice
• Provide the framework for a multidisciplinary quality, safety and satisfaction approach to patient care and service delivery
• Support a ‘no blame, no name, no shame’ learning environment.

The role of community representatives:

• Ensure all discussions are focused on patients
• Push for transfer knowledge from one area of the hospital to all areas quickly
• Act as a Champion in sentinel reviews
My First Project as a Community Representative

Implementation at the JGH
- My role as a community representative
  - Assist in developing policy
  - Participate in roll out
- Lessons learned
  - A hospital is not a top down organization
  - Every change must be explained, not dictated
  - All the staff must buy in to the change
  - Change takes time
Every patient has the right to be treated with dignity, respect and compassion.

Unfortunately, even in the best circumstances, the unexpected can happen. For example, a patient is injured during a fall, or experiences a complication after receiving the wrong dose of medication. In healthcare, we call this type of event an 'accident'.

We regret any instance, however rare, when an accident does occur. In such a case, the patient or their representative has a right to know what happened, why it happened and how a similar accident can be prevented from happening again. This process is called disclosure.

We will provide information to you and/or your representative when an accident occurs. A member of the healthcare team — probably a physician — will speak with you about the accident.

We will give you all the care you need to help you recover, when there are consequences as a result of the accident. Except in an emergency, any changes to your treatment will be explained to you and will be started only with your consent.

We will investigate the circumstances that contributed to the accident. Staff will review the event and you will be kept informed and up to date on all relevant facts.

We will put into place system-wide improvements to reduce the risk of the same type of accident happening again. If you wish, we will keep you informed of our progress after you are discharged.

We will answer all of your questions honestly and openly. At your request, we can also help you contact the Local Service Quality and Complaints Commissioner.

We will continuously strive to deliver the safest, quality health care to you, your family and the community.

This document has been prepared for the exclusive internal use of the Sir Mortimer B. Davis - Jewish General Hospital. Adapted by the JGH Quality Program (2007), with permission from the Health Quality Council of Alberta.
The Speak Up! Program

A program to encourage clinicians and patients, when they do not understand what they are being told or they are uncomfortable about what is happening around them, to Speak Up!
What led to the Speak Up! campaign at the JGH?
SpeakUp!

An Initiative of the
Joint Commission
To Promote Safer Healthcare
Hospital-wide roll out

- Official launch Nov 2011 – Patient Safety Fair
- Patient Safety Fair 2012, 2013
- Board of Directors
- Quality & Risk Management Committee
- Quality & Safety Grand Rounds
- CII teaching / orientation sessions - ongoing
Public awareness campaign

Launch public awareness campaign in the community.

- Press release
- Media interview: city / local newspaper, radio, etc.
- Community presentations
Code of Ethics

Code of Ethical Responsibilities Towards Patients and Statement of Expectations of Patients

Preamble

The Jewish General Hospital (JGH) strives to provide patient care of the highest quality in a safe and ethical manner. The hospital is committed to supporting ethically sound conduct and to providing humane care and attention in a unique and individual way. Its objective to the advancement of medicine is achieved through research and scholarly inquiry conducted in an environment that encourages exemplary practice in the context of outstanding patient care, teaching, and psychosocial concern.

The JGH believes that its involvement in and pursuit of health education and research contributes to the quality of patient care. In individual cases where a potential for conflict exists between the rights, interests, and reasonable expectations of patients and the demands of education or research, those of the patient must take priority. Research and teaching activities must conform to accepted norms of professional ethics. No research related to patients may be done within the hospital without having received prior approval from the hospital's Research Ethics Committee (REC).

In addition to this code, all members of professional orders and associations are also governed by their respective professional codes of ethics.

This code is meant to establish a framework for collaborative relationships between our patients, their families and our staff.
Patient Bill of Rights

• Developed by the JGH Users Committee
  – An elected committee made up of patients and family members.
  – The mandate of the Users Committee is:
    • Informing users of their rights and obligations
    • Fostering the improvement of the quality of living conditions
    • Assessing the degree of satisfaction of users with regard to the services obtained from the hospital
    • Defending the common rights and interests of the users
    • Accompanying and assisting a user in any action
JGH Framework in Support of Ethical Practice
Ruth Hornstein, Markirit Armutlu, Dr. Michael Dworkind, Joseph Erban, Agnetta Hollander, Gurit Lotan, Susan Wener

Purpose/Objective:
This document has been developed to support the JGH Framework in Support of Ethical Practice. The framework is used for assisting JGH healthcare providers, managers, staff, volunteers, and members of the Board of Directors to address ethical issues, and has been designed to facilitate the examination of ethical dilemmas/questions in a systematic fashion.

The JGH Framework in Support of Ethical Practice ensures that the hospital has systems and processes that make ethical decisions, and empower staff to align their decisions, actions, and behaviors with professional and organizational values when addressing difficult clinical or organizational decisions.

Method:
A thorough review of the literature and Accreditation Canada requirements pertaining to ethical frameworks for healthcare organizations was conducted. With the input of Dr. Robert Butcher, questions were designed to help promote conversation and reflection related to the issue at hand.

Results:
The Framework in Support of Ethical Decision Making was developed as a template. Some questions may be more relevant than others depending on the issue. In many cases the framework will be used informally, for difficult or complex decisions the framework should be followed more deliberately and formally, seeking out additional information and/or coming back to the discussion and analysis at another time may also be appropriate and helpful.

STEP 1. Problem:
- What, precisely is the problem that requires solution?
- Who is responsible for taking the action required to implement the solution?

STEP 2. Issues:
- What are the ethical issues at play in this problem?
- Do important values or principles appear to be in conflict?
- What are the legal and regulatory considerations?
- What hospital/professional policies or goals are relevant to the problem?

STEP 3. Stakeholders:
- Who are the relevant stakeholder groups?
- What are their interests?
- Are there conflicts of interest between stakeholder groups?
- Stakeholders should include but need not be limited to patients, future patients, service providers, community groups, etc.

STEP 4. Options and Assessment:
- What are the possible courses of action?
- Does a pressing moral value outweigh normal considerations?
- Does the best option clash with other ethical values?
- Values may include: autonomy, justice (fairness), caring (compassion), privacy, etc.

STEP 5. Decision:
- State the favoured outcome from step 4 above.
- Explain reasons for preferring chosen outcome over the alternatives.
- Apply the TV test.

STEP 6. Implementation and Evaluation:
- Communicate your decision:
  - Who needs to hear the decision(s)?
  - Who will communicate them?
- Turn the decision into action:
  - Develop a clear action plan
  - Provide an evaluation mechanism
- Review decisions in order to verify outcomes.
- Utilize the Continuous Quality Improvement cycle: Plan-Do-Study-Act

Ethics Quality:
Ethics quality issues are distinct in that (1) they give rise to uncertainty or conflict about values, that is, to ethical concerns and (2) the organization's existing systems and processes are inadequate for dealing with those ethical concerns.

Whether an issue is defined as an ethics quality issue or another type of quality issue also depends in large part on the institutional context in which the issue arises.

Conclusion:
Of particular importance is that this framework does not and should not be seen as a replacement to professional codes of ethics. It is a complementary tool that helps with ethical decision making processes. As well, some codes of ethics actually define the conduct expected in certain situations, thus parts of the ethical decision is predetermined.

Acknowledgments: The Clinical Ethics Committee

References:
Ells, Gordon D. Caldicott Gate Health Authority – Board Manual: Framework for Ethical Decision making, August 2003
Failure Mode And Effects Analysis on Reusable Surgical Instruments Circuit

1. INTRODUCTION
- The lack of reusable surgical instruments in the hospital laundry represents an adverse event that affects the quality of patient care, the efficiency of the facility, and the overall safety of patients. This adverse event, within the complex system of reusable surgical instrument management, is typically the result of multiple factors, interactions, and socio-technical processes, which can predispose a hospital to commit and sustain errors.

2. METHODOLOGY
- A flow diagram was generated by the multidisciplinary team of experts based on existing guidelines, literature reviews, interviews, and published materials.
- A root cause analysis was used to examine potential failure modes and their causes, and to score the criticality of each failure mode.
- Multiple significant system errors were identified and corrective actions were developed.
- A proposed redesigned process ensures the 5 Rights: right patient, right medication, right dose, right route, and right time.

3. ORIGINAL PROCESS

4. ROOT CAUSES
- Learn System Errors Identified
- Process improvement study phase
- Improve process control phase
- Select process phase
- Define process phase
- Set workable objectives phase
- Future state analysis phase
- Current state analysis phase

5. RECOMMENDATIONS
- Objective
- Rights
- System operation
- System maintenance
- System improvement

6. CONCLUSION
- Every intervention, from the simplest to the most complex, has an impact on the overall system, and the overall system has an effect on every intervention.
- FMEA methodology not only facilitated the detection of previously unrecognized system errors, but also achieved system solutions.
- In addition, the multi-disciplinary and multi-disciplinary team approach was a good way to support continuous improvement and sound organizational boundaries.
LEARNING FROM ADVERSE EVENTS (CRITICAL INCIDENTS): A process to ensure knowledge transfer across the hospital setting and to the larger hospital community

Objectives of a Critical Incident Review (CIR)
- Enhance patient safety
- Improve clinical practice
- Enrich systems processes
- Upgrade hospital efficiency
- Instill a "just" culture
- Continuous learning by the staff
- Demonstrate accountability at the local level

Critical Incident Reviews
- Required by the Quebec Government
- Process implemented at JGH
- Four Critical Incident Reviews in 2008-09
- Approximately 40 recommendations
- Focus on implementing recommendations
- Accelerate learning experience and improve safety

The Hospital is a 'Learning Organization' (1)
- The sharing of information within the organization using a seamless environment
- A strong sense of teamwork to facilitate collaboration
- Empowered teams and employees
- Strong support from senior and middle management
- Managers as facilitators of working teams
- Senior management provides a clear vision of the future and actively supports middle management
- An open culture of trust
- A strong sense of community and caring within the organization
- An internal structure that helps employees

Benefits of a Critical Incident Review
- Enhanced patient safety
- Improved teamwork and team spirit
- Knowledge gain for the team, the JGH community and the public
- Removal of the stigma of guilt
- Systematic local ownership and action
  - Incident reporting
  - Problem solving
  - Implementation of recommendations

Next Steps
- Pending next Critical Incident
  - In House
    - Critical Incident Committee
    - Summarised CIR Recommendations
    - Follow-up on Critical Incident Recommendations
  - JGH Community
    - Post on JGH Website
    - Highlight during Patient Safety Week
  - Requiring Further Development
    - In House
      - Quality & Safety Grand Rounds
    - JGH Community
      - CIR Team to submit articles to in-house publications and the JGH Website
    - The Public
      - Public Lectures
      - CIR Team to submit articles to external journals

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April 2010

The Process at the JGH

The Critical Incident Review Process

In-House
- Critical Incident Committee
- Summarised CIR Recommendations
- Follow-up on Critical Incident Recommendations
- Public Lecture: "Enhancing Patient Safety through the Critical Incident Process"

JGH Community
- CIR Team to submit articles to in-house publications and the JGH Website

Public
- Critical Incident Review: "Critical Incident at JGH"

References
“There is no greater stakeholder in the effort to improve patient safety than patients and their families!”
Member of PFPSC

• Joined in 2012
• Member of:
  – Knowledge Transfer group
  – Speakers Forum group
What Have I Learned

• A hospital is a unique environment
• It is motivated people who drive change
• The patient must be the focus of every activity in the hospital
• Patients can provide a unique perspective and set of resources for the staff
• Its fun!
QUESTIONS
Thank you!

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