

## Supporting Research @ The Vic . . . . .

Research is a powerful example of what can be achieved through partnership. It touches all of our lives in one way or another today and offers us hope for tomorrow. Along with your generous support, Vic R&E is making new strides toward medical advances.

Please contact Susy Santos at (204) 477-3372 or [ssantos3@vgh.mb.ca](mailto:ssantos3@vgh.mb.ca) if you are interested in fund raising, becoming a donor or volunteering at the Victoria Institute of Clinical Research and Evaluation (Vic R&E).

Visit: <http://www.vgh.mb.ca/vicre> for more info.

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## Thank you Reno!

Vic R&E is fortunate to have had Reno Molinari as Chair of the VGH Foundation Board of Directors, for the past two years.

We are grateful for his dedication and outstanding contributions.

We are equally privileged to welcome Pierre Campeau as the new Chair. Pierre is a great leader who is committed to the Vic and its missions. We look forward to many more great successes under Pierre's direction.

## Welcome Pierre!

## Coming soon...

Along with ACITeam members, our Patient Safety Consultant and the Education team, Vic R&E will be launching three new programs this fall:

- 1) **Information is Power**
- 2) **Good News at the Vic**
- 3) **Specialized and Dignified Care**

Please stay tuned to learn more about these new valuable initiatives and to find out how to get involved.

[Http://www.vgh.mb.ca/vicre](http://www.vgh.mb.ca/vicre)

Fall 2010



**We are the link that bridges policy, investigation, education and service delivery for the best possible clinical practice.**

The Victoria Institute of Clinical Research and Evaluation (Vic R&E) is an experienced multi-disciplinary team committed to providing the highest quality of evidence-based research and evaluation, using ample initiatives to advance care into new domains.

Vic R&E's mission is to be a compassionate, creative and accountable unit while transforming healthcare. Our philosophy is one that seeks continually to improve and invigorate the services for our population. We are grateful to be able to enhance and further findings of new and valuable healthcare design. We look forward to continually respond to ever-changing varieties of research and evaluation needs as well as encourage further breakthroughs that change and enrich lives.

**We are pleased to accommodate industry-sponsored clinical trials.**

### Interested in Research? We can help!

We provide assistance to people who are interested in Research. We offer an accommodating and accessible environment to internal and external researchers alike. We conduct all three types of research; academic, quality improvement and industry-sponsored.

Please direct your questions to Janice Wong - [jwong5@vgh.mb.ca](mailto:jwong5@vgh.mb.ca)

**We now also outsource program evaluations; through comprehensive analysis and report dissemination.**



**Become a Volunteer!**  
Participate in our ground-breaking and all-inclusive research and evaluation projects.

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Make a contribution to the cause dear to your heart.

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**Contact Us!**  
If you have any funding opportunities for Vic R&E.

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## RATIONALE

- Patient safety has become a key policy priority in the Canadian healthcare system
- The findings of the Canadian Adverse Events study and the establishment of the Canadian Patient Safety Institute have galvanized support for policies directed at improving patient safety
- The Winnipeg Regional Health Authority (WRHA) has identified a strategic need to place less emphasis on comparing error rates, and more emphasis on open reporting, full disclosure, and identifying areas for system improvement and safeguards.

## OBJECTIVE

- Our objective was to assess the culture of safety among hospitals in the WRHA and to propose strategies to promote more open reporting of medical errors
- Most hospitals have a relatively standardized method of defining medical errors, the manner in which they are detected and reported however can differ dramatically

## METHODS

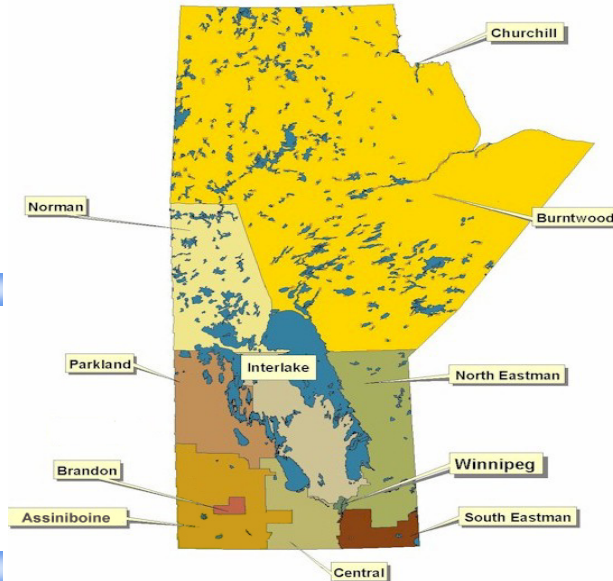
- The WRHA evaluation of the culture of safety in its healthcare institutions is ongoing
  - 1. Provide a baseline measure of the culture of safety
  - 2. Determine if the implementation of patient safety briefings and/or Leadership WalkRounds would enhance patient safety and facilitate system improvements
- Two measures of success were identified:
  - 1. *Process measures* – Have safety briefings and/or leadership WalkRounds enhanced awareness of issues related to patient safety
  - 2. *Outcome measures* – have the number of patient safety incidences reported over the duration of the study changed with regard to baseline measures?

## ACKNOWLEDGEMENTS

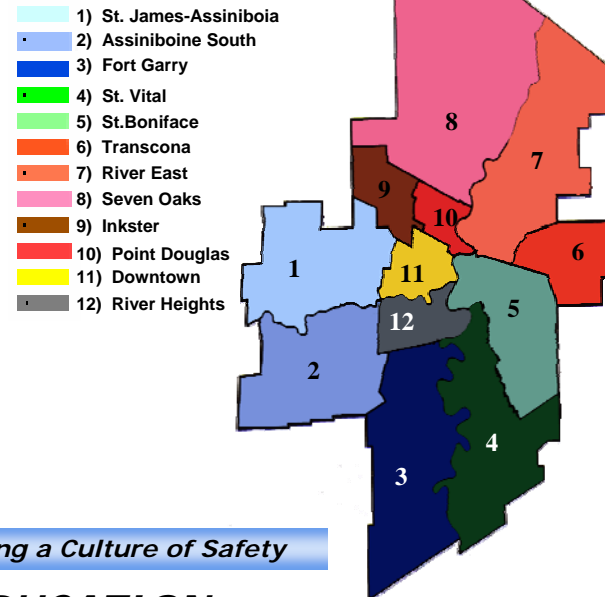
This training opportunity was supported (in part) by a Western Regional Training Centre studentship funded by a Canadian Health Services Research Foundation, Alberta Heritage Foundation for Medical Research and Canadian Institutes of Health Research

## OVERVIEW

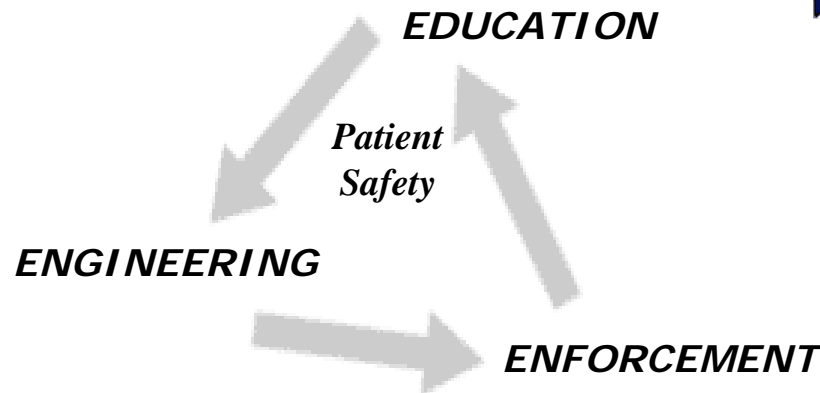
### Regional Health Authorities of the Province of Manitoba, Canada



### Community Boundaries of the Winnipeg Regional Health Authority, Winnipeg, Manitoba



### The Three "E"s of Fostering a Culture of Safety



*"The most fruitful lesson is the conquest of one's own error. Whoever refuses to admit error may be a great scholar but he is not a great learner. Whoever is ashamed of error will struggle against recognizing and admitting it, which means that he struggles against his greatest inward gain."*

Goethe, *Maxims and Reflections*

## THE PROBLEM

- Gaining the support of managers and healthcare professionals
  - Fear of disciplinary action
  - Time pressures
  - Fear of reprisal and peer disapproval
  - Program was not organization-wide
  - Safety responsibilities were not clearly defined
  - Lack of perceived benefit
- Demonstrated the success of similar programs instituted elsewhere, managerial commitment was sought, key leaders identified, and clearly defined safety responsibilities were identified

## RECOMMENDATIONS

- Prove that a problem exists
- The philosophy of the program must be clear to those involved
- Develop a sense of ownership in the program
- Break with tradition
- Changes in the culture of patient safety should lead to a reduction in medical errors and improvement in quality of care

## POLICY IMPLICATIONS

- Learning to think about system versus individual involvement in medical errors
- Developing strategies for understanding and preventing errors
- Increasing awareness of patient safety issues
- Creating an environment where staff freely share information without fear of reprisal
- Ensuring appropriate assessment, prevention, and intervention strategies are undertaken to improve patient safety.
- Decreasing the number of medical errors that occur

