Alberta Health Services

News Release

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Patient safety improvements arise from third party review

CALGARY – An Alberta Health Services' (AHS) request last year to the Health Quality Council of Alberta to review four potentially serious patient care incidents at the Alberta Children's Hospital has led AHS to take a number of actions.

"The external, third party review that we invited the Health Quality Council of Alberta (HQCA) to undertake is important because it provides us with an impartial perspective on how medical systems, policies and procedures are carried out with the goal to make improvements that will benefit patient safety," said Margaret Fullerton, interim Vice President, Alberta Children's Hospital.

Three of the incidents involved medication errors; two children received more than the required drug dosages, and one child received medication intravenously that was intended for administration through a gastrostomy tube (a tube placed in the stomach for feeding). In the fourth incident, a child received the incorrect expressed breast milk from a woman other than the child's mother.

In all four incidents, staff recognized and reported the errors and immediate action was taken to ensure each child received the appropriate care. Safety learning reports were submitted and AHS discussed the incidents with the patients' families. Alberta Health Services has discussed the review with the families involved, as well as staff and physicians at the Alberta Children's Hospital. AHS follow-up to the review is still ongoing.

"We are pleased that our findings are being thoroughly reviewed by AHS and that several recommendations have already been implemented at the Alberta Children's Hospital," said Dr. John Cowell, Chief Executive Officer, Health Quality Council of Alberta. "Our goal was to ensure any new patient safety learnings would not only be shared at the Alberta Children's Hospital but also be shared widely throughout Alberta Health Services so the health system throughout the province would learn from these experiences."

Alberta Health Services is releasing the HQCA's Executive Summary of the Quality Assurance Report. Some details of the review of the incidents are confidential and legislation requires that they remain so. We are continuing to work with HQCA on the release of a report that would not breach confidentiality concerns.

In addition, AHS must respect the right to privacy of patients and their families, as well as being sensitive to staff and physicians who strive to provide the best care at all times.

Actions are underway at the Alberta Children's Hospital and throughout AHS. Actions being implemented at the Alberta Children's Hospital include:

- development of standardized procedures for tracing and labeling all infusion lines
- making equipment adjustments to eliminate the ability to connect gastronomy tube products to intravenous lines

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- ensuring Clinical Nurse Educators spend increased time with staff (specifically staff new to an area or unit) to ensure thorough orientation of specific unit routines
- reinforcing existing processes for storing, requesting and feeding expressed breast milk, including the requirement of double-signature (clinician and parent)
- designing nursing care plans tailored particularly for those children with very complex health needs
- implementing safety action teams on each patient care unit which include front line staff members

In addition to the actions outlined above, there has also been an ongoing AHS review, not completed, of the human factors involved in the incidents. Because these are personnel matters, they will remain confidential.

In addition, the former Calgary Health Region had implemented a new electronic safety learning reporting system and philosophy to enable awareness of potential safety issues to be addressed in order to make care delivery safer for future patients.

The unit on which the events occurred was one of the pilot units in the development and implementation of the reporting system, and unit staff has been strongly committed to the development of the safety culture throughout Calgary.

Alberta Health Services is also committed to expanding the electronic safety learning reporting system and its philosophy throughout the province, based largely on experience gained from the Calgary pilot, so that the same opportunities can be provided throughout Alberta.

Dr. Jim Kellner, Professor and Department Head of Pediatrics, Alberta Children's Hospital and University of Calgary, noted that AHS is continuing to review the HQCA report and will take every possible opportunity to implement actions to improve patient safety.

"We are committed to continually learning and improving to ensure that the safety and quality of patient care is the highest possible," Dr. Kellner said. "We thank the staff at the Alberta Children's Hospital (ACH) who reported these incidents so that we could have the opportunity to learn from them and we thank the HQCA for its review."

Alberta Health Services is the provincial health authority responsible for planning and delivering health supports and services for more than 3.5 million adults and children living in Alberta. Its mission is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

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