Building Capacity for System Transformation: Exploration of Patient Safety Phenomena in Rehabilitation and Complex Continuing Care

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“Number 1 priority. Number 1 priority is patient safety. I think everything that we do revolves around their safety and progressing them or however we interact with them. I think in the back of our mind even though we are not conscious of it, it is constantly the number 1 priority.”

Objectives
- Review of the literature
- Toronto Rehab SAFE Framework
- Purpose and Significance of the Study
- Study Design
- Results of the Study
- Discussion and Implications for Practice
- Future Research Directions

Current Knowledge in Patient Safety
- In acute care
- In rehabilitation
- Enablers of and barriers to patient safety
  - Organizational culture
  - Systems approach
  - Leadership
  - Measurement and reporting
  - Learning needs

SAFE Framework
“Building a Safety Culture”

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<tr>
<td>Systems approach</td>
<td>Apply Learning</td>
<td>Finding Solutions</td>
<td>Evaluation</td>
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Positive Patient and Family Outcomes

Purpose of the Study
From the perspective of staff members:
- What are the phenomena of patient safety within rehabilitation and complex continuing care?
- What are the characteristics of the current workplace culture that act as enablers of or barriers to patient safety?
- What are the learning needs of staff members to enable a culture of patient safety?
Rationale and Significance

- National priority
- New accreditation standards – CCHSA
- New learning for Toronto Rehab
  - Directions for patient safety agenda
  - Professional development opportunities
  - Promoting an enabling patient safety culture
- Contributions to the patient safety literature specifically for rehabilitation and complex continuing care

Study Design

- Qualitative study using focus group methods
- Participants included Toronto Rehab staff with patient contact
- Seven focus groups conducted with a maximum of 10 participants/group
- Focus groups conducted using a semi-structured interview guide with open-ended questions
- Ethical approval granted and confidentiality and anonymity assured to participants

Participant Group

- Total of 66 staff participants in 7 focus groups
  - Inter-professional staff and support staff in clinical and non-clinical roles
  - Majority of participants: Female; full-time employees
  - Experience at Toronto Rehab: majority with 1 – 5 years; 16+ years
  - Education: majority with Bachelor’s level or graduate degrees

Thematic Analysis

- Constant comparative approach used
- Themes emergent from focus group transcripts
- Triangulation of investigators to ensure consistency of meaning and derivation of themes

What is Patient Safety?

“It is multi-level. It is physical, it is spiritual, it is emotional – safety is multi-layered…I sort of see it as a sense of comfort, trust, and a sense of ease, a sense of community – something to do with regularity of communication and familiarity. It is more than just the absence of critical incidents…we all work for the best possible outcomes for our patients.”

RQ 1: What are the phenomena of patient safety within rehabilitation and complex continuing care?

Two main themes emerged:

- Patient population is unique and changing:
  - Unique populations
  - Increasingly complex patient populations
  - Individual risk vs. autonomy

- Rehab’s unique and on-going place in the continuum of care:
  - Rehab is where the work begins
  - Rehab never ends
  - Transitions in care
  - Infection control
Unique populations

“You have got a female patient saying, I woke up in the middle of the night and this man is standing over me…that is the reason the person is here because they are that confused…at the same time, it creates this huge risk in terms of how the other patients are feeling about their safety and their personal space…the patient feels they are not as safe as they should be in their own bed, in their own room.”

Individual risk vs. autonomy

“And even balancing in terms of balancing the issue of making recommendations around patient safety but also balancing that with the fact that we are working with adults who also have a right to choose to not follow your recommendation, so how do we balance those two things and still go home and sleep okay at night?”

Transitions in care: Discharge planning

“I mean I don’t think any of us around the table have vested interest in keeping patients here longer. We all recognize that living in an institution isn’t a great thing … But if we could be confident that we had really good services in the community, there would be appropriate places for people to live and receive care then that wouldn’t be a problem.”

RQ2: What are the characteristics of the current workplace culture that act as enablers of or barriers to patient safety?

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<th>TEAMWORK</th>
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<th>RESPONSIBILITY</th>
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<tr>
<td>• Trust and respect</td>
<td>• Staffing</td>
<td>• Organizational (eg. structures and systems, managing change, corporate/individual program, staff safety)</td>
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<td>• Communication</td>
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<td>• Leadership</td>
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<td>• Inclusiveness</td>
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CULTURE

- Leadership
- Hierarchical structures
- Communication
- Systems approach

Response

“There is still a big hierarchy in this facility and there is still a lot of not feeling safe about being honest and advocating for your patients because people have had consequences as a result of advocating for their patients so it makes you think twice about what you are going to say and how you are going to say it…I think that is a safety issue because if I am afraid to say what I think needs to be said … then I can’t do my job properly and that sort of it strangles me…we have to feel supported, like it is not risky to tell the truth.”

Teamwork

“I think one underlying thing that connected very closely to safety is that issue of trust, in the sense of patients trusting staff, staff trusting each other, staff trusting patients so to speak, as you said, if you have somebody who is just on the outside coming in that has no, any type of relationship with the patient, all of a sudden that can send somebody into orbit and jeopardize their safety and jeopardize the safety of the staff member.”

Culture

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Organizational responsibility

“I think providing opportunity not just to upper management or management voices but to really come to the clinician and come to the frontline and hearing their perspectives firsthand.”

Staff safety is patient safety

“And that the organization…will provide safety…much as patients can come here and have safety, we can come and expect safety and a safe environment in which to do it, to do our jobs…So we are not looking just at the care of the individual patient but making sure that the equipment is running properly, that we have the supplies that we need, that we can function on a day to day basis…Patient resources, non-patient resources, are safe; systems in place are safe.”

Discussion

- Rehabilitation and complex continuing care settings have unique patient safety phenomena
- Enablers of and barriers to patient safety consistent with those found in the acute care literature
- Learning needs identified

Implications for Practice

- Safety Leadership Walkabouts
- Debriefing sessions
- Teamwork and communication
- Transitions in care
- Program specific needs
- Infection Control

Recommendations for Patient Safety at Toronto Rehab

- Building a Just Culture
  - Patient Safety Leadership Walkabouts
  - Team Debriefing Sessions
- Work-life Enhancements
  - Equipment and supplies
  - Leadership Development
  - Staff Education and Development
- Continuity of Care and Transitions
  - Decrease agency staff use
  - Standardize processes to validate results and actions with patients/families

Implications for Future Research

- Gain perspectives from patients and their families
- Focus on teamwork and communication
- Understand the current culture
- Employ rigorous evaluation measures for any initiatives implemented
Acknowledgements

- Focus group participants
- Funding from the University of Toronto Patient Safety Research Cluster