Transparency of health care safety outside of the institutional setting

Call to action

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Dr J. is a family physician practising in Canada. Each day before she sees her first patient, she reviews the electronic health records (EHR) of her day's patients. The EHR includes information from other health care providers including local hospitals. It also provides a report that identifies the latest medication incidents and near-misses reported by pharmacies in her community, including one that involved one of her patients. The EHR flags several patients she will see today: 3 of them with complex medication regimens and 2 whose recent laboratory test results suggest they might be at risk of a diagnostic error. Dr J. then accesses summary data from the past week, comparing her practice with physicians with similar practices from across the country on a number of metrics, including adverse events experienced by patients—but these are becoming less frequent. These metrics are also available to the general public.

Not all physicians have access to the types of information available to Dr J. But medical practice and the delivery of health care in Canada have been transformed to improve patient safety. Many of these activities can be traced back to the sentinel 2002 report *Building a Safer System: A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*.[1] This report, supported by the Royal College of Physicians and Surgeons of Canada, contains 19 recommendations, many of which have been implemented. These include the establishment of the Canadian Patient Safety Institute, more educational and continuing professional development programs for health professionals on patient safety, and a greater focus on improvement through education and remediation rather than blame, among others. A wealth of patient safety research in Canada, including the Canadian Adverse Events Study,[2] has been published since the 2002 report. This body of evidence has documented the magnitude of the problem of health care safety. For example, we have learned of the dangers during transitions of care and have implemented programs such as medication reconciliation to help mitigate these risks.[3,4] Yet patient safety remains an important challenge in many settings. Recent reviews document continuing harm from recognized safety issues. And a variety of interventions such as medication reconciliation have had limited effects.[5,6]

What lies behind this limited progress? While various evidence-based interventions have been developed to address safety gaps,[7] many of the recommendations from the 2002 report have not been fully implemented, such as the following: adopting nonpunitive reporting policies within a quality improvement framework across the health care system; standardizing the legislation on privacy and confidentiality of personal health information across Canada to facilitate access to patient safety data, while respecting the privacy of patients and providers; and securing funding from federal, provincial, and territorial jurisdictions to invest in information technology infrastructures that support the standardized identification, reporting, and tracking of patient safety data. Taken together, most of the recommendations that have not been fully implemented have a common theme of creating a patient safety culture that supports reporting, learning, and improving the transparency of patient safety data, particularly outside of hospitals and long-term care facilities. Indeed, regrettably, the status of patient safety in Canada outside of the institutional setting in 2020 remains a black box for the most part. For example, family physicians, unlike Dr J. in our opening scenario, cannot access patient safety data in a common, shared database or learn from the adverse events and near-misses experienced by patients seen by their colleagues.

One health profession in Canada where there has been a large increase in the transparency of safety outside of the institutional setting is pharmacy. In 2010, the Nova Scotia College of Pharmacists enacted new standards of practice, which require the pharmacies in that province to report all adverse events and near-misses anonymously to an independent third party; to conduct quarterly staff meetings to discuss adverse events and near-misses; and to complete an annual comprehensive patient safety self-assessment.[8] Since 2010, the pharmacy regulatory bodies in every province and territory across Canada have enacted similar requirements, or are in the process of developing these requirements.[9] A paper published in 2018 summarized the adverse events and near-misses reported by the pharmacies in Nova Scotia over the first 7 years of the requirement.[10] Almost 100 000 events were reported by 301 pharmacies during this period, with about 1% of the events associated with patient harm.[10]

Provincial and territorial regulatory bodies for all health professionals—not just for pharmacists and pharmacy technicians—should require mandatory, anonymous reporting of adverse events and near-misses. If reporting practices for all health professionals are

required within institutions and long-term care facilities, why should there not be similar requirements outside the walls of these institutions? The Nova Scotia experience has demonstrated that health professionals can incorporate reporting and learning from event reports in their practice settings. In addition, information on the most commonly reported events and near-misses reported by pharmacies across Canada would surely be of value and interest to prescribers of medications such as physicians, dentists, nurse practitioners, and others, and should, ultimately, improve prescribing. Finally, as these requirements expand to other health professionals, the data on events and near-misses should not be contained in professional silos. Health professionals can, and should, learn from each other, as is the case in institutions.

We have articulated a vision for transparency of patient safety data in Canada. The benefits of transparent reporting of patient safety incidents and a just culture that supports that reporting will create safer care. This is increasingly important as more care moves outside of institutional walls, particularly for complex patients.

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Competing interests
None declared

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