Measuring Patient Harm in Canadian Hospitals

Patients expect hospital care to be safe, and for most people it is. Despite health professionals' focus on safety, a small proportion of patients experience some type of unintended harm as a result of the care they receive. Concern over patient safety and how patients can be harmed during their hospital stay has grown steadily over the past decade.

Governments, national and provincial organizations, individual health regions and hospitals are all working along with patients to improve safety in hospitals. Tracking and reporting harmful events is vital to improvement efforts. Historically, reporting has been mostly voluntary and focused on particular risks such as infections. There has not been a single measure that gives an overview of harm in Canadian hospitals — until now.

The Canadian Institute for Health Information (CIHI) and the Canadian Patient Safety Institute (CPSI) have developed a new measure of harm occurring in Canadian hospitals, and a national picture is now available.

Findings show that in 2014–2015

- Patients suffered potentially preventable harm in more than 138,000 hospitalizations in Canada, or about 1 in 18 hospitalizations (5.6%).
- Of the patients who experienced harm, about 20% experienced more than 1 harmful event while in hospital.

There are 31 types of harm captured in the measure (see the figure). They were selected because they are associated with evidence-informed practices that can reduce the likelihood of their occurrence. It is important to note that the measure does not cover all harmful events that happen in hospitals — only those that fit into at least 1 of the 31 types of harm. For the harm to be included in the data capture, it must have occurred while the patient was in hospital and required treatment or extended the patient's stay. Because the measure uses administrative data that CIHI collects regularly, it is relatively easy to update.



Additional resources

The following companion products are available on CIHI's website:

- Report
- · Technical report
- Infographic



For data-specific information:

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For media inquiries:

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i. Canada total excludes Quebec and selected mental health diagnoses.

Measurement alone does not decrease harm. To assist hospitals in their patient safety efforts, an improvement resource has been developed to link each of the 31 types of harm to practices that can help reduce their occurrence. The improvement resource describes what clinicians can do to improve safety for the different types of harm. It will allow care teams to spend less time researching what they need to do and more time doing it.

No single action or individual can ensure safe care, but through collaboration and evidence-informed practices, health care can be made safer for all Canadians. Clinicians, hospital management, quality and decision-support representatives, and patients and their families all need to have a hand in moving toward safer care for all.

Figure Hospital Harm Framework

	Health Care-/Medication- Associated Conditions	Health Care— Associated Infections	Patient Accidents	Procedure-Associated Conditions
	 Anemia — Hemorrhage Obstetric Hemorrhage Obstetric Trauma Birth Trauma Delirium Venous Thromboembolism Altered Blood Glucose Level With Complications Pressure Ulcer Electrolyte and Fluid Imbalance Medication Incidents Infusion, Transfusion and Injection Complications 	 Urinary Tract Infections Post-Procedural Infections Gastroenteritis Pneumonia Aspiration Pneumonia Sepsis Infections Due to Clostridium difficile, MRSA and VRE 	— Patient Trauma	 Anemia — Hemorrhage Obstetric Hemorrhage Obstetric Trauma Birth Trauma Patient Trauma Device Failure Laceration/Puncture Pneumothorax Wound Disruption Retained Foreign Body Post-Procedural Shock Selected Serious Event
00	Health Care–/Medication- Associated Conditions Harm related to general care provided and/or medication administered during a hospital s	 Events associated with 	dislocations, bur accident, not dire medical or surgion infections Procedure- nts during surgical and medical devices us	es (e.g., fractures, ns) due to an ectly related to cal procedures -Associated Conditions