MANITOBA INSTITUTE FOR PATIENT SAFETY

Make It Personal: Interview Series

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An Interview with Rachel Ganaden

Developing a Culture of Patient Safety

Rachel Ganaden believes that patient safety is about continually working to make patient care better. In 2016, Rachel saw an opportunity to put this belief into practice in her position as the Manager of Quality & Innovation for the Winnipeg Regional Health Authority (WRHA) Home Care Program. With the support of a MIPS *Dr. John Wade Patient Safety Initiative Grant*, she tackled a challenge common to all health care settings - ensuring that health care consumers receive the right medications at the right time. Rachel told us about how she and her team were able to enhance a culture of safety through this project.

Have a Strong Guiding Philosophy

For Rachel, patient safety happens when clients are involved in their care, are empowered to speak up when they have concerns, and are active decision-makers in their care. Rachel says that transparency is key, "if you are receiving care, you have a right to voice what that looks like for you. Simply, patient safety is engagement of staff, clinicians, and clients, and making sure clients are at the center of care." These beliefs shaped Rachel's pilot project that aimed to enhance medication safety for one home care team in the Seven Oaks Inkster area of Winnipeg.

Collaboration with All Stakeholders

To figure out how to improve care, everyone involved in the care interaction needed to engage in understanding what the challenges were, and why they exist. The project team talked with everyone involved in medication safety to ensure they understood, from all perspectives, where some of the challenges exist. For example, Rachel says, "From talking to clients, care providers and caregivers in an honest way, we learned that in many instances where a medication error was recorded the issue was that clients were choosing not to take their medications, one reason being due to medication side effects. This information really helped us target care improvements."

Another piece of information that was revealed during consultation with care providers was that some care providers were uncomfortable speaking up when a medication error occurred. Rachel's response to that was to make part of the project about creating a culture of safety so that staff would feel more comfortable reporting errors, and feeling like when they did report errors that something would be done about it. "We wanted them to understand that they have the power to do something towards improving patient safety and their own work environment."

Small Steps to the Larger Goal

Promoting a culture of safety was broken down into smaller steps, one being education. For example staff learned about why it is important to speak up when a medication error occurs. Another step was to incorporate knowledge from direct-care staff into developing strategies to improve care. One way in which this was done was care providers contributed to the development of a hand-out that outlines how to manage some of the potential challenges that may be encountered when providing medication support.

Another important step was to ensure a complete feedback loop. Rachel observes, "Often with initiatives, information is distributed out to staff and their feedback collected, but staff don't hear back on how their input was directly used to influence and create positive change. In this case, we developed a feedback loop that made the project more meaningful for everyone involved."

Working Together for a Common Goal

When asked what she learned most from this project, Rachel says, "This was a really strong care delivery team and when given the opportunity to engage in this project, they contributed to a cultural shift that made care delivery even better. Everyone was committed to a common goal. We are grateful to MIPS for giving us this opportunity. From this pilot, we learned some great techniques and approaches that can be spread to additional teams to further improve the care we provide."

This pilot project was also a winner of the WRHA's Quality & Patient Safety Contest in the fall of 2017, an opportunity to recognize success stories of improving quality and patient safety in the region. Rachel is hopeful the next step is to spread this effective, practical and straightforward approach to the rest of the WRHA Home Care Program.

The Manitoba Institute for Patient Safety (MIPS) is an independent, not-for-profit corporation established in 2004 to promote and coordinate activities that improve patient safety and enhance quality healthcare in Manitoba.

Written by MIPS Volunteer, Cara Brown