

## Canadian Patient Safety Institute to host Patient Safety and Quality Improvement Conference

The Canadian Patient Safety Institute will host a conference - **Canada's Forum on Patient Safety and Quality Improvement** in Toronto, Ontario, from April 28-30, 2009. This Forum will provide multiple learning streams with a national and international flavour, including:

- Applied Learning
- Infection Prevention and Control
- Medication Safety
- Patients and Family Involvement
- Patient Safety in Physician Practice
- Technology and Patient Safety

Some of the featured speakers include **Helen Bevan**, Director of Service Transformation, NHS Institute for Innovation and Improvement, **Lise Mathieu**, Retired Brigadier, Canadian Forces; Commander of the Canadian Forces Health System, **Dr. Brian Goldman**, host of the CBC radio talk show *White Coat, Black Art*, and **Dr. Bryan Sexton**, Director of Safety Culture Research and Practice at the Johns Hopkins Quality and Safety Research Group.

The program will provide opportunities for a variety of professionals to participate, including, but not limited to, physicians, nurses, pharmacists, health care providers, educators, leaders, researchers, and board members.

To register for the Conference, or for more information on sponsorship and exhibitor opportunities, visit the CPSI website:  
[www.patientsafetyinstitute.ca](http://www.patientsafetyinstitute.ca)



## Improved care for Acute Myocardial Infarction (AMI) Phenomenal success stories from coast to coast!

The Acute Myocardial Infarction (AMI) Improvement Team at Royal University Hospital, Saskatoon Health Region, is a star in AMI care! The team moved their AMI Perfect Care measure from a baseline of 50 per cent to a monthly average of 92 per cent. This improvement success index ensures patients receive the best possible AMI care in a timely manner.

"This is a remarkable improvement and they were able to achieve it in only eight months. Furthermore they have been able to sustain these gains during the last 10 months," says Virginia Flintoft, Project Manager for the SHN Central Measurement Team. The three care components that the team made the most progress with includes: Smoking Cessation Counseling; performing Percutaneous Coronary Intervention (PCI) within 90 minutes; and prescribing statins at discharge. Involvement in the Western Node AMI Collaborative facilitated learning through application of the Improvement Model, a fundamental underpinning of SHN.

The team has developed a number of tools to assist in achieving and maintaining perfect care components. These include:

- Form letters for discharge that list the medications and require physicians to indicate why patients are not prescribed perfect care medications;
- Preprinted prescription pad with the medications list by classes as a visual reminder for the physician, who fills in the trade name and dosing; and
- Nursing discharge sheets that list preprinted drug classes, to assist nurses in ensuring perfect care.

Recently the Royal University Hospital and Saskatoon Health Region stepped up to the plate to become the inaugural Mentor organization for SHN and the AMI intervention.

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## Phenomenal AMI success stories from coast to coast!

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In doing so, Kelly Johnson, Clinical Nurse Specialist for Heart Health and Maura Davies, President and CEO, have committed to share their improvement methods with AMI care colleagues nationally. This is the best testimonial to the SHN mantra: 'Everyone Teaches, Everyone Learns'.

Theresa Fillatre, AMI Intervention Lead indicates that there is great evidence that SHN AMI Teams are actively working with community partners and Emergency Health Service providers to address the critical elements of pre-hospital care. For example, in New Brunswick, Cleo Cyr and Barbara Hennessy, AMI faculty and team leads, have been instrumental in the development and testing of a multi-department clinical documentation tool that begins with pre-hospital care and follows the patient through the system. Their expressed hope and dream is for New Brunswick Heart Health to adopt the tool as a standardized instrument to improve reliability of AMI care province-wide.

Fillatre states, "It is great to see the leadership the field is demonstrating in addressing the timing issues in care for ST elevation (shown on an EKG) Myocardial Infarction (STEMI) patients. For example, Dr Jan Kornder, Cardiologist and Pam McElheran, Director Acute Care, Fraser Health, Surrey, BC, led the introduction of a STEMI team that has demonstrated remarkable early results. Bernice Budtz, BC AMI faculty acknowledges the leadership of this amazing community hospital team in their system."

### Royal University Hospital, Saskatoon Health Region AMI Results

Measure	Baseline	Goal	Current
Aspirin at Arrival	100%	90%	100%
Aspirin at Discharge	100%	90%	100%
Beta Blocker Prescribed at Discharge	100%	90%	100%
Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival	50%	90%	80%
ACE/ARB Prescribed at Discharge	100%	85%	100%
Smoking Cessation Counseling/Advice	60%	100%	100%
Perfect Care for AMI	50%	95%	92%
Statins at Discharge	73%	95%	100%
AMI inpatient Mortality	1.5%	1.125%	1.5%

Fast track or by-pass protocols and programs for STEMI patients have emerged in provinces such as Manitoba, Ontario, Nova Scotia and Saskatchewan, to name a few. Fillatre identified Southlake Regional and Credit Valley Hospitals in Ontario, as successful examples of establishing Regional PCI Guidelines through nurtured strategic partnerships.

"A good deal of credit goes to nurses like Amanda Darwood and Rachel MacLean who understand the vital importance of standardization of pre-printed order sets, pharmacologic therapy and inter-agency cooperation in improving diagnosis, treatment and outcomes for STEMI patients," adds Fillatre. "Great AMI care really is about well-oiled teams that work as a system."

"The Winnipeg, Manitoba STEMI Program is another shining example," says Fillatre.

"At St. Boniface Hospital, Lillian Hall's team and colleagues have taken the crucial first steps to an improved system of care for their constituents. Of great importance is their willingness to share lessons learned, tips, tools and ideas with their national counterparts."

At the Royal University Hospital in Saskatoon, new protocols have been put in place to reduce stretcher-to-stretcher transfer time and duplication of medical procedures, such as ECGs for STEMI patients. A holding bay is set up in the Cardiac Catheterization Lab (Cath Lab), prior to patients arriving at the hospital.

Paramedics and residents attend to patients in the holding bay until the Cath Lab is available. Admitting staff will also register the patient while in the holding bay.

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## Phenomenal AMI success stories from coast to coast!

*Continued from page 2*

On October 23, 2008, Dr Stephen Fort, Director and Lindsay Murphy, Manager of the Cardiac Catheterization Lab at the QE11 Health Sciences Centre, Capital Health, Halifax, Nova Scotia, performed 'the first in-field to door PPCI'. The total time from ECG to first inflation took '30 minutes'. Such programs maximize the use of advanced-prepared paramedics in the field in initial identification of the STEMI patient, the formalization of protocols for Emergency Department by-pass, and direct access to Cardiac Catheterization Labs.

Fillatre adds, "All AMI teams should be proud of their improvement. I encourage all teams to share their experiences as there is always a 'gem in the story' that others will find useful in their process improvements."



### Improve Care for Acute Myocardial Infarction

Dr. Jack Tu, AMI Faculty lead, recently published three articles on AMI Quality Improvement, including information on the new set of CCORT/CCS (Canadian Cardiovascular Outcomes Research Team/Canadian Cardiovascular Society) AMI quality indicators. To learn more, link to these articles:

*Use of evidence-based therapies after discharge among elderly patients with acute myocardial infarction* (Peter C. Austin, PhD, Jack V. Tu, MD PhD, Dennis T. Ko, MD MSc, and David A. Alter, MD PhD) CMAJ 2008;179 895-900 [www.cmaj.ca/cgi/content/full/179/9/895?etoc](http://www.cmaj.ca/cgi/content/full/179/9/895?etoc)

*Factors associated with the use of evidence-based therapies after discharge among elderly patients with myocardial infarction* (Peter C. Austin, PhD, Jack V. Tu, MD PhD, Dennis T. Ko, MD MSc, and David A. Alter, MD PhD) CMAJ 2008;179 901-908 [www.cmaj.ca/cgi/content/full/179/9/901?etoc](http://www.cmaj.ca/cgi/content/full/179/9/901?etoc)

*Indicators of quality of care for patients with acute myocardial infarction* (Jack V. Tu, MD PhD, Laila Khalid, MD, Linda R. Donovan, BScN MBA, Dennis T. Ko, MD MSc for the Canadian Cardiovascular Outcomes Research Team / Canadian Cardiovascular Society Acute Myocardial Infarction Quality Indicator Panel) CMAJ 2008;179 909-915 [www.cmaj.ca/cgi/content/full/179/9/909?etoc](http://www.cmaj.ca/cgi/content/full/179/9/909?etoc)

## Notes from the Central Measurement Team

Contributed by Virginia Flintoft  
Project Manager,  
Central Measurement Team

### Celebrating AMI

On October 21, 2008 the "Indicators of quality of care for patients with acute myocardial infarction (AMI)" was published in the *Canadian Medical Association Journal*. Dr. Jack Tu, the National Lead for the *Safer Healthcare Now!* AMI faculty was the chair of both the Canadian Cardiovascular Outcomes Research Team and the Canadian Cardiovascular Society Acute Myocardial Infarction Quality Indicator Panel, of which I had the honour of being a member.

In our continuing effort to remain aligned with national Quality Improvement Indicators, the

changes (additions, deletions and refinements) to the new AMI indicators will be an important guide to *Safer Healthcare Now!* (SHN) as we make decisions regarding our AMI measures.

As we mentioned in the May newsletter, the AMI teams are demonstrating remarkable success in achieving the evidence-based goals for the AMI intervention measures and are unquestionably able to sustain their improvement.

Of the teams reporting AMI measures: ASA on arrival, ASA at Discharge, Beta Blockers at Discharge, and Statins at Discharge, over half provided best care to all of their patients 100 per cent of the time for at least a year.

Twenty-five per cent of the teams also provided ACE inhibitors or ARBs at discharge, and Smoking Cessation counselling to all of their patients, all of the time. Delivering Thrombolytics to STEMI patients within 30 minutes of arrival or PCI within 90 minutes continues to be challenging, however, some improvement has been observed in the monthly means in the past year, which have ranged from 43 per cent to 86 per cent and 34 per cent to 72 per cent respectively. The impact of these results is observed in the monthly mean scores for Perfect Care ranging from 43 per cent to 73 per cent and Inpatient AMI mortality from 11 per cent to a low of 1.3 per cent.

## Treating myocardial infarction: A matter of teamwork

Contributed by: Nathalie Nadon, M. Sc.,  
Cardiology Nurse Practitioner;  
Suzanne Champoux, B. Sc., Nurse; and  
Dr. André Kokis, Cardiologist

The Centre hospitalier de l'Université de Montréal (CHUM) is a tertiary cardiology centre, as well as a reference centre for angioplasty. When the acute myocardial infarction strategy was presented to the Cardiology Department, we were in the process of bringing together CHUM's three cardiology teams at a single site, Hôtel-Dieu.

An initial analysis of the files revealed that the necessary procedures (early administration of aspirin, prescription of a beta blocker, an ACE inhibitor or a statin upon discharge) were performed in accordance with good practices. However, it was noticed that the recorded "door-to-balloon" (DtB) time was longer than the target value suggested in the guidelines and that the measures taken by healthcare professionals to deal with their patients' smoking habits were either nonexistent or not documented in the patients' files.

The analysis of the process revealed that the median DtB time in 2004-2005 was 120 minutes for patients treated at CHUM. The main causal factors were delays in obtaining the first ECG and in calling the hemodynamics specialist and the on-call team.

The healthcare team, needless to say, was shocked. A team made up of a cardiologist, a specialized nurse practitioner and a research nurse was quickly assigned to find ways to reduce these delays and improve the measures taken by the professionals to address their patients' smoking habits.

We have met with all the professionals concerned in the Emergency and Hemodynamics departments. Considerable staff shortages have resulted in exhausting shifts, so when these healthcare professionals were informed that their efforts were yielding poor results, the news was met with strong reactions. Our challenge was to convince them that they could find solutions in spite of the constraints placed upon them. Our willingness to implement the proposed solutions rapidly yielded the desired results.

The measures listed below were identified as possible solutions.

- ECG technician on site 24-hours a day for triage
- Immediate reading of the ECG by the emergency physician
- "Code STEMI" call made simultaneously to the hemodynamics specialist and the on-call team
- Assignment of on-call duty to technicians based on their place of residence

A nurse was also hired to analyze all the details pertaining to DtB time. The results of this analysis are regularly sent by e-mail to all the persons concerned.

## Quebec Campaign

*Together, let's improve  
healthcare safety!*

These measures led to a spectacular improvement in results. DtB time was down to 78 minutes in the second quarter; and 91 minutes in the third quarter.

With regard to helping patients quit smoking, we have developed tools and training for all nurses who work with this clientele. All patients who smoke will soon be offered nicotine replacement therapy to decrease their withdrawal symptoms during their hospital stay and to help them quit smoking. They will also be referred to the *J'ARRÊTE* telephone help line or to a smoking cessation centre.

Finally, the Québec campaign: *Together, let's improve healthcare safety!* was an excellent opportunity to improve the care we provide. All of the professionals also realized they have key roles to play in improving the quality of care.



VTE Intervention Coordinator, Lynn Riley and AMI Intervention Lead, Theresa Fillatre are all smiles during a recent VTE road show in Atlantic Canada. They were stuck on a highway between New Brunswick and Nova Scotia that was closed for eight hours, due to a blizzard.

## AMI Faculty profiles



Barb  
Hennessy

### Barb Hennessy's commitment to high standards of care

When Barb Hennessy was asked what motivated her to become involved with Safer Healthcare Now! she said, with gentle humor, "I was volunteered while on vacation." Although there is some element of truth in this response, it does not do justice to Barb's interest and commitment to setting and achieving high standards of care.

Barb has always focused on providing and promoting excellence in clinical care and most of her 25-years plus career has been centered on cardiovascular and critical care nursing. Barb has served as a leader for the acute myocardial infarction (AMI) initiative in the South West District Health Authority, New Brunswick, in addition to being a very active National Faculty member for the SHN AMI intervention.

Barb began her career in the late 70s after graduating with a Diploma in Nursing from Bathurst School of Nursing. Barb continued her studies, graduating with a Bachelor of Nursing in 1987 and Master of Nursing in 1999 from Dalhousie University.

Her professional volunteer work has been at the local, provincial and national level and includes

working with the Canadian Advanced Practice Nurses and the Atlantic Cardiac Rehab Network. As a Clinical Nurse Specialist she brings strong academic preparation and clinical expertise to her role as an educator, clinician and leader.

Barb is proud of her team's results related to AMI care and said, "I believe strongly that what we are doing makes a positive impact in the health and safety of our patients."

Her leadership and willingness to partner and share her time and expertise has been a driving force for the team's success and for the achievements of teams across Canada that participate in the AMI intervention.

'Traffic cop, coach and cheerleader' are metaphors Barb uses to describe herself. "Bridge-builder" may be another metaphor that reflects her search for opportunities to build partnerships towards better care. When asked about what she is most passionate about Barb said, "Healthcare partnerships for best outcomes - that is partnerships between people (patient and healthcare practitioners), communities (locations and healthcare organizations) and government (local, provincial and federal).

Barb's contribution as AMI faculty has been invaluable. Barb has been a reliable source of excellent information and insight on how to improve AMI Care. Barb not only led the implementation at her facility, but also has given her time and expertise to promote best practice in AMI care at the National level. Barb's knowledge, experience, critical thinking questioning, and collaboration have helped to ensure the AMI standards we support are in the best interest of the people we serve.



Cleo Cyr

### Cleo Cyr - a constant bright light in AMI care

After working over 35 years in healthcare, Cleo Cyr, maintains a steadfast commitment to patient care and a belief that we can always improve. Cleo enjoys working as an integral member of the healthcare team and says, "We need to work together to provide the best possible patient care. Throughout the years, meeting the needs of the 'patient' has been my primary focus."

Cleo recognized a gap between current and best practice for Acute Myocardial Infarction (AMI) care and took an opportunity to lead AMI quality care improvements in her organization and as an AMI faculty with *Safer Healthcare Now!* Cleo has provided excellent leadership to her team and has shared their learnings at the provincial and national level."

Cleo entered healthcare in the early 70's after graduating from Victoria Public Hospital School of Nursing with a Diploma in Nursing. Cleo continued her education throughout her career taking courses and programs related to critical care, health and wellness promotion, illness treatment, disease management and organizational management and development. She earned the American College of Sports

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## QEII Halifax, has first successful "in-field to door" primary PCI

Primary Percutaneous Coronary Intervention (PPCI) is a procedure used to open an infarct-related artery during an acute myocardial infarction with ST-segment elevation using urgent angioplasty.<sup>1</sup>

The QEII interventional cardiologists recognized the growing evidence supporting the superior results from PPCI intervention compared to thrombolysis and, therefore, began offering their services over three years ago on a 24-hour, seven day a week basis to patients presenting to the QEII. The results were, and continue to be, extremely positive for the patients who had access to this treatment. The outcomes have included a decreased death rate by greater than 50 per cent, while

also decreasing morbidity and length of hospital stay.

The empirical evidence and local success led to a goal of gradually expanding this option to include more people who could benefit from PPCI. A project was initiated to offer PPCI to patients in metro Halifax by working with Emergency Health Services (EHS) to redirect patients directly to the cardiac catheterization lab within the Halifax Infirmary, thereby bypassing many of the hurdles that would normally delay the timeliness of this intervention.

The first successful case occurred, October 23, 2008. Time from initial diagnostic ECG to completed PPCI was 30 minutes.

The patient's family contacted EHS at 13:25. They arrived on the scene at 13:32, moved the patient from their vehicle to the ambulance and assessed them by 14:05. The QEII cardiac catheterization team was contacted at 14:06 and preparations were made immediately to receive the patient. The PPCI patient arrived in the lab at 14:15 and the procedure was completed by 14:35, restoring normal blood flow.

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<sup>1</sup> Ellen C. Keeley & L. David Hills (2007). Primary PCI for Myocardial Infarction with ST-Segment Elevation. *The New England Journal of Medicine*, 356:1, 47-54.

## Cleo Cyr - a constant bright light in AMI care

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Medicine Clinical Exercise Specialist Certification in 1998, the Canadian Nurses Association Cardiovascular Nursing Certificate in 2001, a Bachelor of Nursing in 2002 and a Masters in Health Studies in 2005 from Athabasca University.

When asked about her AMI team's success, Cleo says they have been able to achieve, surpass some and maintain their improvement goals in the delivery of AMI care. Cleo is very impressed with the care team's reduction in time from door to ECG and door to Percutaneous Coronary Intervention (PCI). The greatest improvement has been integrating tobacco reduction strategies throughout the continuum of care using such interventions as the Ask/Advise/Assist and pharmacotherapy including Nicotine Replacement.

This team also developed a documentation tool that follows the patient's care path from initial contact, through treatment to discharge. This tool has been widely distributed and adapted in organizations across Canada and is available in both French and English languages.

Cleo's engagement of a patient-centered team, commitment to care and willingness to share has had a positive impact on the quality and safety of AMI care locally and nationally.

Some advice Cleo would provide to organizations and teams is to establish a collaborative practice environment that engages stakeholders to contribute their expertise in providing and improving care.

Cleo says, "as a leader you need to be visible, be available, and listen to all sides. To succeed in improving care you need to create a shared understanding and commitment, align interventions with stakeholder interests, communicate the big picture while breaking it down into doable parts and value everyone's contribution in the process."

When asked about her favorite saying Cleo gave a few: "Oh, for heaven's sake!" "Get a grip!" and "Live, love and be happy." Cleo is a constant bright light, who brings clinical and managerial knowledge, skill, and experience to her work but what is most outstanding is her positive energy and dedication in working with others to provide excellent patient care.

## QEII Halifax "in-field to door" primary PCI

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As a result of this outstanding teamwork the patient returned home, has resumed normal activities, and is currently being followed up in the Cardiology Clinic.

The Division of Cardiology and Department of Emergency Medicine along with EHS are working together to ensure appropriate patients are directed to the interventional cardiologists for PPCI. Appropriate patients are those meeting the same criteria as the majority of patients for thrombolytic therapy and currently located within the metro Halifax area.

Inclusion and exclusion criteria are as follows:

### Indications for Primary PCI

- ST segment elevation MI within 12 hours of symptom onset
- Cardiogenic Shock
- Contraindications to thrombolysis

### Absolute Contraindications to Primary PCI

- Known terminal co-morbidities to limit lifespan less than one year
- i.e. lung disease, malignancy
- Unable to obtain consent from patient or family member
- Moderate to severe dementia
- Known Creatinine > 200µmol/L, or on dialysis
- Prior CABG (coronary artery bypass grafts) - unless contraindication to thrombolysis
- Known PVD (peripheral vascular disease) - unless contraindication to thrombolysis WITH palpable femoral pulse.

QEII is among the Canadian cardiac leaders, along with Foothills

Hospital in Calgary, Alberta and the Ottawa Heart Institute in Ontario, in offering PPCI to ST-Segment Elevation Myocardial Infarction (STEMI) patients as the 'gold-standard'. The key to the success of this project has been collaboration and effective communication with key stakeholders committed to bringing the best evidence into practice to ensure the highest standard of care is available in a timely manner.

Dr. Stephen Fort said, "It is a complex process and everyone needs to be on-board and relatively focused. Communication and collaboration are essential to achieving this goal. Our team has worked hard to make it a success."

When looking toward the work ahead Dr. Fort said, "We need to take baby steps as we work to widen our scope. We do not know how far this may advance geographically, but we need to continue to pursue opportunities that ensure the best possible care is available to the largest number of patients."

There is a growing awareness that PPCI is the treatment of choice for STEMI patients. The challenge is to find innovative ways to deliver PPCI in a timely manner to the people who could benefit from this treatment. It is important for the medical community and government to consider ways to use existing resources better and to invest in the development of an infrastructure with the capacity to allow new ways to deliver the best care.

## Alice Romaine—Nova Scotia's first PPCI patient

Alice Romaine is a 71-year old woman who was one of the first people in Nova Scotia to undergo Primary Percutaneous Coronary Intervention or PPCI. Alice is the mother of six children, grandmother of 13 grandchildren and great grandmother of six great grandchildren. Alice and her husband Vic live in Halifax, Nova Scotia. Alice enjoys her family, reading, television, housework and daily walks.

**Thursday, November 6, 2008**

Alice had returned from a routine visit with her family physician where her blood work reports were good and her blood pressure was fine. Alice and her dog Duke went to pick up the mail then returned to the house. When Alice removed her jacket the pain struck. Alice said "I never felt anything like it. It went across my chest and down my arms. I was home alone so I sat on the bed." Vic came in about two or three minutes later and Alice told him he needed to take her to the hospital. Alice says Vic told her, "you must be having a heart attack; I am calling 911."

Alice explained that she lives close to the fire hall so the paramedics were quick to respond. They administered nitro spray and oxygen, started an IV and did an EKG. Alice said, "I felt I was in good hands." On the way to the hospital the paramedic was talking to the doctor when Alice felt another sharp pain. They told her it was a heart attack. The paramedic was instructed to take Alice directly to the cardiac cath lab when they got to the hospital.

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## Call to Action to Prevent Deep Vein Thrombosis and Pulmonary Embolism

A *Call to Action* to reduce the number of cases of deep vein thrombosis and pulmonary embolism has been issued in the United States, urging Americans to learn about and prevent these treatable conditions.

Deep vein thrombosis and pulmonary embolism affect an estimated 350,000 to 600,000 Americans each year, and the numbers are expected to increase as the U.S. population ages. Together, deep vein thrombosis and pulmonary embolism contribute to at least 100,000 deaths each year.

Deep vein thrombosis is a blood clot in a deep vein, most commonly in the lower leg or thigh. The clot can block blood flow and cause pain, swelling, and skin discoloration. In the most serious cases, deep vein thrombosis can lead to a pulmonary embolism — when part of the blood clot breaks loose and travels through the bloodstream to the lungs, obstructs blood flow to the lung tissue, causing damage to the lungs or other organs from lack of oxygen.

"Deep vein thrombosis and pulmonary embolisms are often 'silent' conditions — they can occur suddenly and without symptoms," said Acting Surgeon General Steven K. Galson, M.D., M.P.H. "But we have made a lot of progress in understanding how these disorders develop and how to prevent, diagnose, and treat them. It's time to put this knowledge into action."

"Being hospitalized or confined to bed rest, having major surgery, suffering a trauma, or traveling for several hours can increase a person's risk of deep vein thrombosis and pulmonary

embolism," added Galson. "We want to increase the awareness and knowledge of these potentially deadly conditions and encourage patients and healthcare providers to take the steps to prevent them."

The Call to Action urges a coordinated, multifaceted plan to reduce the numbers of cases of deep vein thrombosis and pulmonary embolism nationwide.

The plan emphasizes the need for:

- Increased awareness about deep vein thrombosis and pulmonary embolism.
- Evidence-based practices for deep vein thrombosis.
- More research on the causes, prevention, and treatment of deep vein thrombosis.

The Agency for Healthcare Research and Quality (AHRQ) contributed to the Call to Action with the release of two new guides — one for patients and another for healthcare providers — on how to prevent dangerous blood clots. The Call to Action to Prevent Deep Vein Thrombosis and Pulmonary Embolism 2008, is available at [www.surgeongeneral.gov/library/calls/index.html](http://www.surgeongeneral.gov/library/calls/index.html)

*Safer Healthcare Now!* launched the Venous Thromboembolism (VTE) intervention in April 2008, led by Dr. William Geerts and Lynn Riley of Sunnybrook Health Sciences Centre.

For further information, or to access the Getting Started Kit, visit [www.saferhealthcarenow.ca](http://www.saferhealthcarenow.ca) and click on Interventions.

### Alice Romaine

*Continued from page 7*

Alice says she went in around 3:00 pm and was out in CCU by 5:30 pm. Alice knows her family was there, but does not remember some things. Alice was awake during the procedure and had to lay still. "I did not feel anything, they used freezing." The nurses offered sleeping medication, which Alice declined. Alice slept thru the night.



Alice Romaine—Nova Scotia's first PPCI patient

### Friday, November 7, 2008

"The nurses were so nice, they are all nice." A nurse came in and said I could get out of bed. Alice had breakfast, was able to move around, go to the washroom, and attend to her personal care. That morning she was transferred from CCU to the floor where she continued to be monitored over the weekend. Monday morning Alice was discharged to her home.

### December 2008

Alice feels good and is getting back to her normal life. Alice is back to her 1.5 hour walk with her dog Duke, is preparing for Christmas and looking forward to enjoying the holidays with her family. When asked what she thought about her experience she said, "I feel good, it is better than surgery. It doesn't take long to heal and you can get up the next day."

## New Safety Improvement Advisor joins the Western Node

*Safer Healthcare Now!* (SHN) is pleased to welcome a new Safety and Improvement Advisor (SIA), Nancy Campbell. Nancy joins Tanis Rollefstad, also an SIA for the Western Node, in assisting SHN teams with their quality improvement and measurement initiatives.

Nancy previously worked with Alberta Health Services (Chinook area), where she was an improvement facilitator focusing on flow initiatives in primary care, medical specialists and other Chinook Health programs. Nancy is a certified critical care nurse and played a key role with the implementation of *Safer Healthcare Now!* topics (VAP, AMI, CLI and RRT). She has been instructing Advanced Cardiac Life Support for numerous years and completed her Master of Science from the University of Lethbridge this year.



Nancy Campbell

Nancy resides in Lethbridge, Alberta, and will work from a virtual office. You can reach her at [nancy.campbell@hqca.ca](mailto:nancy.campbell@hqca.ca)

### Western Node - Staffing Update

Christina Krause will continue to work with the Western Node through an in-kind arrangement with her new organization, the BC Patient Safety and Quality Council. You can continue to reach her at [christina.krause@hqca.ca](mailto:christina.krause@hqca.ca). Congratulations Chris on your role!

## National MRSA Webinar

Environment Cleaning: How Hamilton Health Sciences has integrated quality measurement in everyday life!

Date: February 25, 2009

Time: 10:00–11:00 AM (PST); 11:00 AM–12:00 NOON (MST); 12:00–1:00 PM (CST); 1:00–2:00 PM (EST); 2:00–3:00 PM (AST); 2:30–3:30 PM (NST)

Guest Speaker: Cindy O'Neil, Infection Control Practitioner, Hamilton Health Sciences, ON

### Supporting faculty:

- Michelle MacRae (Housekeeping Supervisor, St. Boniface Hospital, Winnipeg, MB)
- Michael Gardam (Director, Infectious Diseases Prevention and Control Ontario Agency for Health Protection and Promotion)
- Leah Gitterman (Technical Specialist Infection Prevention and Control University Health Network)

### WebEx:

<https://cpsl-icsp.webex.com/cpsl-icsp/j.php?ED=107007902&UID=0>  
\*Enter your name and email address, Click "Join Now"

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### Quebec Campaign —

*Together, let's improve healthcare safety!* (TLIHCS)  
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