Revalidation Oversight Committee

January 12, 2017 Meeting Notes

ATTENDEES

MEMBERS

Co-Chairs	Dr. Lynn Stevenson	Associate Deputy Minister, Ministry of Health	IP
	Dr. Dorothy (Sam) Williams	Chair, Health Authority Medical Advisory Committee- Island Health	IP
Patient Representatives	Christine MacKinnon	Patient Representative	IP
	Maggie Schulz	Patient Representative	IP
Regional Quality and Practice Leaders	Dr. Mary-Lyn Fyfe	Chief Medical Information Officer- Island Health	IP
	Dawn Nedzelski	Chief Nursing Officer- Island Health	IP
	Dr. Adele Harrison	Executive Medical Director, Quality and Safety – Island Health	IP
	Dr. Jennifer Grace	Executive Medical Director, Medicine- Island Health	VC
NRGH Leaders and Staff Representation	Dr. Georgia Hirst	NRGH Chief of Staff, Site Medical Director of Operations	IP
	Dr. James Capstick	NRGH Medical Staff- Anesthesia	IP
	Dr. Mike Kenyon	NRGH Medical Staff- Critical Care	IP
	Natasha Talbot	Clinical Nurse Educator, NRGH	IP
	David Forbes	Manager, Clinical Pharmacy Programs- NRGH	IP
	Suzanne Fox	Executive Director, Geography 2	IP
Peers	Dr. Eric Grafstein Dr. Keith Dipboye	CMIO, Vancouver Coastal Health CCIO, CST Project	IP IP
Secretariat	Craig Mercer	Director, Project Methodology, Acting for Jessica Arril, Executive Project Director, IHealth	VC
	Kimberly Jensen	Client Care Executive, Cerner	IP
BCPSQC	Andrew Wray	Director, BC Patient Safety Quality Council	IP

GUESTS

BCPSQC	Dr. Doug Cochrane	Provincial Patient Quality and Safety Officer	VC

IP = In Person, VC = Videoconference, TC = Teleconference, R = Regrets

Item	Purpose	Lead
Call to Order, Welcome by Chairs, Introductions		**Chairs**
Dr. Lynn Stevenson, Co-Chair and Associate Deputy Minister of Health called the meeting to order at 1730h. There were round table introductions where members introduced themselves and spoke to their background and reason for being at this table, as defined by their positions detailed above.		
Introduction and Setting the Stage	**Dr. Lynn Stevenson and Dr. Doug Cochrane**	**Chairs**
Dr. Stevenson spoke to the role of the Revalidation Oversight Committee. It is defined in recommendation number 23 of the Cochrane Recommendations of the Cochrane Review of IHealth. The reason for the presence of the Ministry of Health at the table was explored. The Ministry is committed to moving forward with a focus on patient care. The Ministry of Health has responded here to concerns regarding quality of care at the Nanaimo site due to the EHR. The Ministry of Health, in conjunction with Island Health and all those on site at NRGH working with the Cerner system, is committed to working collaboratively and openly in this process of revalidation. Dr. Keith Dipboye, CCIO, Clinical and Systems Transformation (CST) initiative and Dr. Eric Grafstein, CMIO, Vancouver Coastal Health are attending to ensure that lessons learned from IHealth can be considered for the Clinical and Systems Transformation (CST) initiative.		

Dr. Stevenson encouraged members to be candid and respectful in their comments in order to ensure success of the Committee, reiterating that patient care is the unifying factor. In addition, Lynn reiterated that the co-chairs are committed to a transparent process of reporting on the activities of the Revalidation Oversight Committee but the principle of what is said in the room stays in the room must be adhered to as attribution outside of the committee will prevent members from being candid.

Dr. Cochrane:

Dr. Doug Cochrane, Provincial Patient Quality and Safety Officer focused on the process for revalidation outlined in recommendation #23.
There have been differences in opinion on the system which vary depending on the type of work we ask of the system (Nephrology vs ICU vs ED).
There are multiple issues that have interfered with the ability to effectively deliver care. From the many interviews done, it was apparent that certain parts of the system were not working in ways that people expected (e.g. display of information reflecting RN activities and transfer of medication lists across the spectrum).
It has been troubling to him that this tool, procured for the purpose of improving care, is being reported to reflect a decrease in the delivery and effectiveness of care. "Why is this?" is the question that must be answered through our process of revalidation.

The basic question is as follows. What is working? What is not working- and why is it not working?

Do we have a tool that is implementable in the context of BC Health Care?
To say to throw this tool out is too simplistic. We have heard that parts of the system do work and we have heard that parts do not. Is it because of different expectations; or is it because of underlying capability of the system and environment?
We need to define the strengths and the weaknesses of the system.
Example: processes that do not function for what they are designed to do. What are these?
Example: documentation in the context of RN: Patient ratio.
Example: are there examples where we turn to Cerner and present a programming problem to them?

Questions/comments from the floor to Dr. Cochrane:

1. How do we define that tipping point that says we are good enough?
   Answer- we need to define what is easy to fix and what is not easy to fix.
   This is about the delivery of care and use of the system to deliver care.
2. Critical care providers feel that there are significant issues with the implementation in critical care at NRGH. In this environment, medication error is 9% of our error. 60% of error is procedural. Therefore, any failure with respect to medications with the Cerner system is an unacceptable increase in error. Our critical care representative noted that major issues to do with work flow exist. The Critical Care service is looking forward to aiding in defining changes to the system that will allow for a system that will work well in the ICU.
3. There are significant issues of trust - trust of each other and trust of the system. There was agreement around the table that there is much work that has to occur to build trust. We will build trust by going through this process together.
4. The interface is central and must remain a central focus of this work.
5. A focus on processes including BPMH and transitions in care must be maintained
6. What will success look like for revalidation? There was general consensus that work is needed to define this.

General Discussion:

1. Is there a level of fatigue at the Nanaimo site that makes this process not possible? This process will be time intensive.

2. What are the expectations of IHealth? What are the expectations of IHealth by this group?
3. Building a software system is analogous to building a building. We are all behind one patient, one record, one plan for health and care. There has been a great deal of effort by our CMIO as we have moved ahead. There are groups who feel that a significant fix is required to make this system safe for delivery of care.
4. The tsunami detectors that detect safety issues are the staff and they have been tremendously involved. The heart of this is people taking care of people. The tool is just a support in the delivery of care. The challenge here is how we set up a process that can show where the system can and cannot be used.

Summary from BCPSQC

1. The role of this committee is to:
   a) Define the process for developing the working groups
   b) Oversee that the process is occurring
   c) Confirm revalidation process
   d) Set the expectations of the revalidation process
   e) Clarify the goal of this committee= this is the first step in the road map.
2. The processes defined must start with the provision of care to patients using this tool in a specific situation or environment. The stories are the beginning. The basic issue is "does this tool help people to do their job"? We all have the right to ask questions and be granular enough in the working groups to determine whether we have to change a process (and can live with it); or whether the system can be used as is.

Summary from Co-Chairs:
There were reflections that although everyone present is approaching the discussion from a different perspective, it is important that the Committee have the same goals. Are committee members willing to be persuaded by data and willing to work together? What are the principles governing this process moving forward? Trust and commitment are necessary for the Committee to move forward.

Next Steps	**Discussion/Decision**	
It was suggested that the Committee reconvene on Thursday, January 19: Jobs for the next meeting: 1. Review of Terms of Reference for this committee. 2. Review of process to define and populate working groups 3. Commitment to this process.		
Adjournment		Chairs