LHSC answers your questions about:

The Canadian Adverse Events Study

What is the Canadian Adverse Events Study?
The study, sometimes called the Baker Norton Report, is the first national study of adverse events in Canadian healthcare. The study describes an adverse event as an unintentional injury or complication that is caused by healthcare management, rather than a patient’s underlying disease or illness, that leads to death, disability, or a longer hospital stay.

What did the study find?
The study found that approximately 7.5% of hospital admissions led to adverse events in Canada in 2000. The researchers recommend that hospitals move to a common way of collecting safety-related information so that problems in the healthcare system can be identified and understood. At present, hospitals across the country have different systems to track safety issues.

How does LHSC track safety issues?
LHSC does not track “adverse events.” In the past, we have tracked “occurrences,” which can include any incident from an unknown drug allergy to a theft on hospital property. We will look at the way we collect safety-related information in light of this report.

How did the researchers get their information?
The researchers looked at 3,700 hospital charts from 20 hospitals across Canada. The report did not assess paediatric, obstetric, or mental health patients.

Highlights from the Canadian Adverse Events Study

Based on its review of 3,700 patient charts from across Canada for the year 2000, the study estimated that:

- 7.5% of patients in Canadian hospitals could experience an adverse event. This estimate amounts to 185,000 admissions out of 2.5 million.

- Approximately 37% of adverse events are thought to be preventable.

- The rate of adverse events for Canadian teaching hospitals is similar to the rate in the U.K., and better than the rates for other hospitals in Denmark and Australia.
**Was LHSC one of the hospitals involved in the study?**

To protect the privacy of patients, the report does not name the hospitals that were a part of the study or discuss any details about individual cases. The researchers say the purpose of the study is not to lay blame, but to look at how the hospital system as a whole can be improved.

**What will happen next?**

Hospitals and healthcare organizations have been waiting for the Canadian Adverse Events Study to be published so they can review the recommendations and begin working together to make changes.

As a hospital, LHSC welcomes this report. We work hard to prevent injuries and complications from occurring in the first place, and our physicians and employees continue to work with other hospitals and health partners to improve the overall safety of the healthcare system. We believe the information and recommendations in this report will help hospitals provide better care to all patients across Canada.

**Do I need to worry about my safety?**

Patients can be confident in the care they receive at LHSC. We pride ourselves on the skill, professionalism and dedication of our physicians and staff. If you have concerns at any time, please discuss them with your doctor or nurse.

**Where can I get more information?**


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**How LHSC is working to ensure your safety**

We know that even one preventable adverse event is one too many. Our hearts go out to patients and healthcare professionals across Canada who have experienced this type of situation.

LHSC is committed to providing a safe and healthy environment for patients, staff, physicians, partners and visitors. Our goal is to be a leader in the practice, promotion and research of best patient safety practices. Through the work of our Patient Safety Steering Committee, we will continue to build on our many safety accomplishments.