cpsi icsp

Canadian Patient Safety Institute

Institut canadien pour la sécurité des patients

Safe care... accepting no less

“If I could change one thing to improve patient safety, it would be to ensure that everyone asks questions. It would be great if patients and families were to ask physicians and staff, “*Why and what are you doing? What is this medication? What is the purpose of that test?*” and if nurses would ask doctors more often “*Is it normal if …? Can you explain why you...?*”

Dr. Édouard Hendriks, Vice President Medical, Academic and Research Affairs
Horizon Health Network | CPSI Board Member

BOARD MESSAGE

Maura Davies, Board Chair
Canadian Patient Safety Institute

Providing safe care is a priority for every healthcare provider; however, despite best efforts and intentions, harmful incidents that impact patients and families, as well as providers and organizations, can, and do, happen. The role of the Canadian Patient Safety Institute (CPSI) is to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. This transformation is built on integrity and honesty in conversation, and the power of learning and sharing that will ultimately lead to broad improvement in patient safety and quality. CPSI continues to coordinate efforts that help patient safety and quality improvement initiatives grow.

The voice of the patient/client/resident is so important to the success of our work. Listening is not enough. We need to welcome patients and families as true partners in making our healthcare system better. The conversations and decisions change dramatically when this happens. Their valuable insights, information and experiences can have a positive impact on safe care. I encourage all healthcare organizations and systems to include the perspective of patients and their families when making decisions and planning safety and quality improvement initiatives.

As the chair of CPSI's board of directors, I am pleased to serve along with an outstanding group of individuals who take the time to share their views and advance the patient safety agenda. Their leadership, expertise and individual thinking are truly reflected in their passion, drive and excitement for a shared vision of *safe healthcare for all Canadians*.

I would like to thank Hugh MacLeod and his team at CPSI for their hard work and dedication, and extend my appreciation to all providers across the healthcare continuum who are making a difference in patient care by improving practices, experiences and outcomes. Through engagement, accountability and support, our shared vision for safe care is attainable. We all need to accelerate our efforts to ensure every patient receives safe care, every time. Nothing less is acceptable.

CEO MESSAGE

Hugh MacLeod, CEO
Canadian Patient Safety Institute

I am a lucky guy. In my role as CEO of CPSI, I get to hear about and see patient safety excellence delivered by passionate care providers. I also get to meet and talk to leaders who dare to transform system failures into learning opportunities and advocate transformation that will make healthcare safer for all.

I have had the honour of being in the company of patients and family members who have suffered harm and want to help the system improve its patient safety record. They remind us why we are here and who we are here to serve. Our mantra, ASK.LISTEN.TALK., creates an important shift through a new conversation among providers and between providers, patients, residents and clients. Through conversation, we can find the patient safety solutions to the challenges facing us today.

While patient safety progress is happening, the toll of harm still exists. With your efforts we can create a tidal wave of patient safety improvement. “We” means all of us. We all have either the legal or moral authority to promote quality and patient safety; some have both. Collectively, we have the power to make healthcare accountable to the patient, resident or client.

I want to thank CPSI's board for their support, and the staff for the dedication they bring to every file, product and service. You are truly remarkable.

We invite you to learn more about our work as set out in this annual review.

Improved Safety and Quality Practices, Experiences, Outcomes.

The Canadian Patient Safety Institute (CPSI) is a not-for-profit organization that exists to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. Funded by Health Canada, the Canadian Patient Safety Institute reflects the desire to close the gap between the healthcare we have and the healthcare we deserve.

Effective Governance for Quality and Patient Safety

Getting boards on board with patient safety so that they know the questions to ask and what to listen for is critical if we want to improve the quality of care. Since 2010, CPSI has delivered the Effective Governance for Quality and Patient Safety program to over 700 board members and CEOs, giving them innovative health governance practices, resources and tools to ensure effective oversight of quality and patient safety in their organizations. This year sessions were held in Alberta, Prince Edward Island, Nova Scotia and Ontario. Additionally, a customized program for community-sector board trustees was delivered in Ontario.

Developed by CPSI and the Canadian Health Services Research Foundation, the unique program is making a difference. As well as educational sessions, it includes the Effective Governance for Quality and Patient Safety Toolkit, a tremendous resource for healthcare organizations. Toolkit in hand, healthcare governors have a structured framework to guide excellence in governance practices. To purchase a copy, visit patientsafetyinstitute.ca.

"Success will be defined when the voice of patients and families are heard and included at all levels of healthcare planning and delivery."

Ms. Susan Mumme, Senior Vice President Quality and Healthcare Improvement Alberta Health Services | CPSI Board Member

The Patient Safety Education Program™ CANADA

The Patient Safety Education Program – Canada

The Patient Safety Education Program – Canada (PSEP – Canada) is engaging frontline professionals and taking the quality and patient safety culture of organizations to new levels. PSEP – Canada has a cadre of 26 master facilitators who certify patient safety trainers, giving them the training and resources to ask, listen and talk about patient safety.

Three sessions were held in 2011/2012: a session partnering with the Ontario Hospital Association; a faculty-focused session in partnership with Queens University; and a specialized session with an emergency/intensive care unit focus. More than 200 participants attended these sessions.

Developed by CPSI, in partnership with Northwestern University, PSEP – Canada is built on an inter-professional train-the-trainer team model that leverages peer-to-peer relationships to guide patient safety education. It is changing the patient safety culture in organizations; Bridgepoint Health customized a program and trained 88 patient safety champions who are applying their learning to work-based, clinical practice improvement projects. Trillium Health Care trained 45 patient safety champions and provided bimonthly lunch-and-learn events that, to date, has attracted over 300 participants.

Excitingly, the PSEP – Canada curricula will soon be a creative resource for a patient safety program for post-graduate medical residents. Scheduled for launch in 2013, the program is being developed by a steering committee composed of 13 national organizations, along with the Royal College of Physicians and Surgeons of Canada acting as the secretariat. For information on upcoming sessions, visit patientsafetyinstitute.ca/education.

Safety Competencies

Healthcare organizations are achieving safer patient care by incorporating CPSI's *Safety Competencies* framework into educational programs and professional development activities. These core competencies enable frontline Canadian healthcare providers to deliver safe care. Educators and professionals are also using the CPSI e-mapping tool and process to integrate patient safety content into curricula. The tool and process allows them to assess students and identify gaps in safety content in order to address shortcomings and highlight areas for faculty development.

Curriculum mapping is currently under way with the Association of Faculties of Pharmacy of Canada, Canadian Association of Schools of Nursing, Canadian Registered Nurse Examination Committee, Canadian Medical Protective Association Good Practices Guide, and on demonstration by a group of hospital and community directors of quality and safety who are members of the Canadian Association of Paediatric Health Centres.

Canadian Patient Safety Officer Course

The Canadian Patient Safety Officer Course was a huge success this past year, with participation from 65 Canadian healthcare professionals, including six from Hong Kong. In this interactive workshop, participants increase their skills and knowledge, and develop practical strategies and solutions for patient safety challenges in their organizations. This is also an opportunity for quality and patient safety professionals to network with colleagues and exchange innovation. The four-day course is delivered in partnership with the Canadian Healthcare Association (CHA). For information on upcoming sessions, visit patientsafetyinstitute.ca/education; contact the CHA at cha.ca to register.

"We can learn from the patient experience – look at what happened and why, listen carefully to those affected and involved, find ways to better understand both the patient and provider, report patient safety events, rethink your assumptions and beliefs, and redesign systems to be safer."

Ms. Jean Cox, Assistant Deputy Minister
Manitoba Health
| CPSI Board Member

Improving Care Search Centre

With up to 100,000 page views per month, the Improving Care Search Centre is a pillar of knowledge transfer and information sharing. Quickly becoming a go-to website, it is changing the way patient safety and quality improvement information is shared, searched and gathered by bringing it together in over 600 indexed websites. Using a Google-like search feature, users choose what information they will receive on topics such as falls prevention, medication safety, hand hygiene, surgical safety and more. To access your requested knowledge with a click, visit improvingcaresearchcentre.com.

By asking, listening and talking, we grow Canadian patient safety and quality initiatives and help others grow theirs. This year, many organizations joined the conversation and sought solutions with Global Patient Safety Alerts, a cutting-edge tool that contains indexed summaries and links to patient safety advisories, alerts and actions. With a robust and growing collection of almost 700 inventoried alerts from 23 contributing organizations in eight countries, this web-based platform provides a forum for users to share their experiences, connect with experts in the field and learn from others in implementing solutions and strategies on specific patient safety incidents. Support tools are also available at globalpatientsafetyalerts.com, including links to CPSI's Canadian Incident Analysis Framework and Canadian Disclosure Guidelines.

"Patient safety initiatives grounded in real stories of patient experience provide the compelling urgency for change."

Ms. Heather Davidson, Assistant Deputy Minister
Planning and Innovation
British Columbia Ministry of Health | CPSI Board Member

Patient Safety Crosswalk

Patient Safety Crosswalk is an information-sharing resource that profiles organizations and patient safety and quality improvement initiatives. Crosswalk is continually updated with patient safety news, events, projects, research and more from healthcare organizations across Canada. Visit patientsafetycrosswalk.ca to quickly access the latest news and patient safety information.

Engaging Patients in Our Work

When patients are harmed in healthcare, they want their voices heard, but they also want to hear from the voices of the system that harmed them. They want to know what happened, to hear "I'm sorry" and to be reassured that steps are being taken to prevent similar incidents in the future. With our partners, CPSI provides support and guidance for healthcare providers in these difficult circumstances.

Following extensive consultation, the Canadian Disclosure Guidelines was updated to reflect the evolution of a patient-centered and safety-focused culture in healthcare. Symbolizing a commitment to patients' right to be informed if they are involved in a patient safety incident, the guidelines promote a clear, consistent approach to disclosure, emphasizing the importance of inter-professional teamwork, and supporting learning from patient safety incidents. Download a copy from patientsafetyinstitute.ca.

Those responsible for, or involved in, analyzing, managing or learning from patient safety incidents have a new tool in their hands with the updated Canadian Incident Analysis Framework. It is based on the Canadian Root Cause Analysis Framework, with new information, knowledge, methods and tools to support organizational learning and quality improvement, foster a safe and just culture and improve the success of analysis in enhancing the safety of patient care. Download a copy from patientsafetyinstitute.ca.

"It is important that leaders listen, remove barriers and empower staff to make changes at the level of care delivery to make the system safer."

Ms. Sharon Goodwin, Vice President Quality and Risk and Chief Practice Executive VON Canada | CPSI Board Member

Patients for Patient Safety Canada

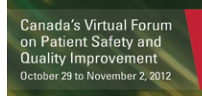
If you could talk to someone who has been harmed, what would you say? The greatest stakeholders in improving patient safety are patients and their families. Patients for Patient Safety Canada (PFPSC) is CPSI's patient-led program that champions the voice of the patient. PFPSC ensures that healthcare organizations and systems include the perspectives of patients and their families when making decisions and planning safety and quality improvement initiatives. Members collaborate with stakeholders at all levels across the healthcare system, deliver presentations, and share stories and lessons learned. To learn more or to become a member of PFPSC, visit patientsforpatientsafety.ca.

Canadian Patient Safety Week

Thousands of patients, healthcare providers and organizations from across Canada put the spotlight on patient safety issues, shared best practices and talked about how to grow patient safety and quality initiatives during Canadian Patient Safety Week, October 31 to November 4, 2011.

The theme was *"Good healthcare starts with good communication"*, encouraging healthcare professionals, patients and their families to ask questions, listen carefully and talk openly. Over 1,100 registrants received patient safety packages, including posters, table tents, placemats, games and activities. To shine light on the work organizations are doing, customized options were available that allowed organizations to place their logos on creative materials.

First launched in 2005, Canadian Patient Safety Week is a hallmark national campaign to inspire extraordinary improvement in patient safety and quality. It will be held from October 29 to November 2, 2012. Register at asklistentalk.ca.



Canada's Virtual Forum on Patient Safety and Quality Improvement

The first ever Virtual Forum on Patient Safety and Quality Improvement, hosted across the country from October 31 to November 4, 2011, was a huge success. More than 2,000 participants tuned in to this unique and groundbreaking event. Over 20 hours of inspirational videos, informative presentations and compelling panel discussions were broadcast to 700-plus sites in Canada and 17 countries around the world. And because participation was virtual, 620 tonnes of CO_2 emissions were saved.

The forum profiled six patient narratives, reinforcing the importance of including the voices of patients and their families in patient safety discussions. A national hand hygiene video competition was also held, and 14 videos from across Canada were shown as a fun, creative way to promote good hand hygiene.

Canada's Virtual Forum on Patient Safety and Quality Improvement will take place from October 29 to November 2, 2012. The program includes sessions on leadership and culture, infection control, medication safety, falls, as well as reflections and progress on the question "Is healthcare safer?"

Focused Research

Research creates new conversations. Since 2005, CPSI has initiated several open research competitions and funded over 70 research projects, dozens of studentships, numerous fellowships and a research chair.

CPSI now supports projects aimed at expanding the scope and scale of patient safety research and building capacity for high-quality patient safety research in Canada. In many cases, the research is co-funded in partnership with national or provincial research funding. By collaborating with researchers, policy makers and frontline users, CPSI targets patient safety initiatives that will lead to significant healthcare system improvements across the continuum of care through the transformation of evidence into action.

"One of the biggest challenges to patient safety and quality improvement is the "mind blindness" that prevents us from recognizing our own unsafe acts. Ask questions and open your mind to the perspective of your patients."

Dr. Doug Cochrane, Chair British Columbia Patient Safety and Quality Council | CPSI Board Member

Eight research projects were completed in the 2011/2012 fiscal year. One was an effort to understand the true financial costs of preventable harmful incidents. *The Economics of Patient Safety in Acute Care* report was led by principal investigators Dr. Edward Etchells, associate director of the University of Toronto Centre for Patient Safety, and Dr. Nicole Mittmann of Sunnybrook Health Sciences Centre.

The report reinforces the need to continually evaluate the costs of harmful incidents to the entire healthcare and social system. More importantly, it strongly advocates conducting methodologically sound research to determine the best interventions and strategies for improving patient safety.

"At one point or another, all Canadians will be a patient in the healthcare system. Talk about, listen to, and learn from their experiences to help build a culture of patient safety."

Ms. Michelle Kovacevic, Associate Assistant Deputy Minister Health Canada | CPSI Board Member

"Patients and their families play a vital role in their own care. We need to actively involve them and listen to their concerns and observations because they bring a unique perspective to patient safety."

Ms. Emily Lap Sum Musing, Executive Director of Pharmacy, Clinical Risk and Quality University Health Network | CPSI Board Member

Safety at Home: A Pan-Canadian Home Care Safety Study

Over 900,000 Canadians receive healthcare services in their homes every year. A 21-member research team is studying the prevalence, magnitude and risk of patient/client safety incidents in home care settings across Canada. The final report will be released in January 2013. Funding of over $1.2 million has been provided by CPSI, Canadian Institutes of Health Research's Institute of Health Services and Policy Research, Institute of Aging, Institute of Musculoskeletal Health and Arthritis, Institute of Circulatory and Respiratory Health, The Change Foundation and the Canadian Health Services Research Foundation.

Safer Healthcare Now!

Safer Healthcare Now! (SHN), CPSI's flagship program, is investing in frontline providers and the delivery system to improve the safety of patient care with initiatives known to reduce avoidable harm. An easy-to-access, informative and engaging program, it promotes and supports networks to share change ideas and experiential learning related to implementing, sustaining and spreading patient safety practices. *Safer Healthcare Now!* has almost 700 Canadian healthcare organizations enrolled.

The strength of *Safer Healthcare Now!* is the clinical teams and organizations who continue to advance their patient safety and quality improvement initiatives. They are applying the interventions, and patients and families are sharing their stories to better the processes of care. The patient safety leadership and support of health ministries, quality and patient safety councils, boards, healthcare leaders, regional CPSI staff, intervention leads and volunteer clinical faculty have also been essential enablers of success.

Safer Healthcare Now! continues to build formal structures and processes such as the web-based Communities of Practice, a mentorship program, learning collaboratives, national calls, faculty and formal learning programs, and knowledge exchanges to support the ever-changing needs of its customers. The Getting Started Kits for each intervention are core documents that organizations and clinical programs are using nationally and internationally. The 12 Getting Started Kits are available at no charge and were downloaded over 26,000 times last year. This year, nine of the Getting Started Kits were developed, reviewed or revised to provide the most current evidence available. For more information, visit saferhealthcarenow.ca.

Measurement and Patient Safety Metrics

Teams ensure that *Safer Healthcare Now!* interventions are working with Patient Safety Metrics, a web-based data submission and reporting system that helps them collect and analyze improvement data. It is a free, easily accessible, centralized source for data management. Some 75 process and outcome measures are tracked. Between March 2011 and January 2012, almost 23,000 data points were entered. To document and monitor performance over time, customized reporting is also available, providing multi-site and indicator reports. A dashboard is in development and expected to be available later this year.

National Call Webinars and Learning Collaboratives

To keep conversations about patient safety flowing, *Safer Healthcare Now!* hosts national patient safety webinars and learning collaboratives on topics specific to interventions, as well as on general strategies to accelerate quality improvement and measurement. Teams and individuals exchange information and inspirational success stories, building collective and individual knowledge and strengthening capacity and capability in patient safety.

Over 44 national calls were coordinated last year, with over 2,700 lines open across all the calls. More than 120 teams/organizations participated in national learning collaboratives. In addition, regionally customized programs on medication safety, falls and related injury prevention, and provincial performance improvements in acute myocardial infarction care, spread and sustainability were developed with a variety of partners.

"Patients know better than anyone what they need. Focus on listening, on seeing patients as the true expert in their pathway to wellness, and on building the relationship; it will automatically increase safety."

Ms. Catherine Gaulton, Vice-President
V.P. Performance Excellence and
General Counsel Capital District Health
Authority | CPSI Board Member

CANADIAN PATIENT SAFETY INSTITUTE BOARD OF DIRECTORS
(Back row, left to right) Catherine Gaulton, Sharon Goodwin, Doug Cochrane, MD, Jean Cox, Ward Flemons, MD, Susan Mumme, Keith Dewar (Vice-Chair), Vasanthi Srinivasan, Heather Davidson *(Front row, left to right)* Édouard Hendriks, MD (Treasurer), Emily Musing, Hugh MacLeod (CEO), Maura Davies (Chair), Tyler James, Micheline Ste-Marie, MD *Missing:* David Hill (Secretary), Michelle Kovacevic, Deborah Prowse and Sherri Wright

Infection Control

In the hospital, superbugs and most other bacteria and viruses can be spread between patients, on pieces of equipment and on unclean hands. Supported by *Safer Healthcare Now!*, the Infection Prevention and Control intervention is providing resources, links and timely information on infection control, and helping Canadian healthcare organizations implement strategies to reduce superbugs and optimize hand hygiene practices. New this year, the Stop Infections Now! Collaborative is an 18-month improvement program to help institutions improve compliance with evidence-based strategies to reduce infections. There are currently 24 teams participating in the collaborative.

Reducing Falls and Injuries from Falls

An exciting new virtual Falls Facilitated Learning Series is improving patient safety by making it easy for teams to get the information they need. Developed by CPSI, in collaboration with the Registered Nurses' Association of Ontario, the virtual series was delivered to 43 teams from acute care, home care, long-term care and mental health sectors across Canada. Participants also received a newly developed Falls Prevention Sustainability and Spread workbook. The Saskatchewan Falls Collaborative helped 26 teams, enrolled in a 10-month program, reduce the incidence of falls and injury from falls by 20 per cent in participating home care and long-term care facilities.

Stop! Clean Your Hands Day

STOP! Clean Your Hands Day was a great success, with about 1,000 sites across Canada registering this year in an effort to improve hand hygiene. This national event is held each May, and is promoted by CPSI, Accreditation Canada and the Community and Hospital Infection Control Association – Canada. This year, STOP! Clean Your Hands Day included a national video and a sticker design competition.

The uptake on Canada's Hand Hygiene Challenge, tools, resources and programs has been phenomenal and continues to grow. The Patient and Family Guide has been updated and copies can be freely downloaded. To date, more than 20,000 healthcare workers, students and volunteers have completed the online Hand Hygiene Education Module. CPSI also converted the Hand Hygiene Self-Assessment Framework, developed by the World Healthcare Organization, to help organizations reflect on existing practices and achievements and focus on future plans by identifying key issues requiring attention and improvement. To access these valuable online tools to promote optimal hand hygiene, visit handhygiene.ca.

Medication Safety

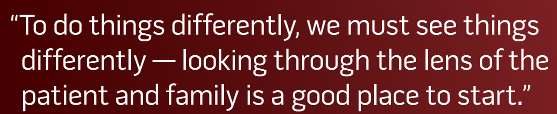
Improving patient care means asking, listening and talking about medication. Medication Reconciliation (MedRec) is a formal process healthcare providers use with patients, families and care providers to ensure that accurate and comprehensive medication information is communicated across transitions of care.

In partnership with the Institute for Safe Medication Practices Canada and supported by a strategic advisory group of leaders from 10 national healthcare organizations, CPSI is doing much work to advance MedRec from a national perspective. These leaders are focusing on accelerating and optimizing MedRec across the continuum of care.

At the local level, teams working to implement MedRec are accessing two new virtual action series, completed through the work of *Safer Healthcare Now!* This year, CPSI surveyed practice leaders to identify organizations that successfully implemented MedRec to learn about the factors contributing to their success and the challenges that arose.

The strategic advisory group endorsed a joint consensus statement on the impact of medication communication failures, to illustrate the importance of a multidisciplinary approach. A Cross Country MedRec Check-up map to identify supporters, leaders, research and technology related to MedRec across the country has also been developed.

To access the survey and map or for more information on the National Challenge for Medication Reconciliation, visit saferhealthcarenow.ca.



"To do things differently, we must see things differently — looking through the lens of the patient and family is a good place to start."

Ms. Donna Davis, Co-Chair
Patients for Patient Safety Canada

"The way to keep patients safe is to listen to them carefully and really hear what they are saying."

Ms. Carol Kushner, Co-Chair
Patients for Patient Safety Canada

LET THE CONVERSATION BEGIN

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