



A Vital Mandate: An Impressive Start

Report on the Initial Evaluation of
the Canadian Patient Safety Institute



Ottawa, Ontario

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A Vital Mandate: An Impressive Start Report on the Initial Evaluation of the Canadian Patient Safety Institute

Presented to:



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Executive Summary

CPSI is beginning to bring together the many diverse individuals and organizations with an involvement or interest in patient safety. This has and will continue to improve our efforts both by encouraging people to work together, and by avoiding unnecessary duplication.

Survey Participant

This report summarizes the results of an initial evaluation of the Canadian Patient Safety Institute (CPSI). The evaluation was carried out between October 2006 and January 2007 by Dr. Michel Brazeau, Director, Professional Services & Medical Affairs with the Centre de santé et de services sociaux de Gatineau and Sharon Sholzberg-Gray, President and CEO of the Canadian Healthcare Association. The evaluation comes mid-way into the first five-year term of the Institute.

In accordance with an evaluation framework developed by the co-lead evaluators and the CPSI, the evaluation process included three principal modes:

1. A brief electronic survey was distributed to CPSI members and healthcare associations;
2. An interprofessional review panel participated in an evaluation workshop held in November 2006; and
3. Participants in the on-line survey and select other informants were invited to participate in a more elaborate structured interview with Sharon or Michel.

The entire process and the report that follows are built around the Logic Model framework for planning and evaluation. The Logic Model breaks the planning process for any complex undertaking into four component parts: (1) Plans and priorities, (2) processes, (3) outputs and outcomes in the short- and medium terms, and (4) impacts on the long term. This framework is used to present the findings and recommendations below and within the document.

The results of all three modes of evaluation were quite consistent. Participants in the survey, the workshop and the interviews all shared the same positive assessment of the Institute. They also pointed to a similar list of important accomplishments for the first 2½ years of its mandate, and indicated similar priorities for the Institute as it completes its first term.

Plans and Priorities:

Participants in the evaluation process shared a strong sentiment that the mandate of the Institute is a vital one that will require sustained attention and investment. They also agreed that the organization has made an impressive start, managing to accomplish much in 30 short months, and starting “from scratch.” Participants also encouraged the Institute to build on its foundation of success in the second half of its first term by moving forward with a more focused series of goals that are more fully integrated into all aspects of its business plan. These goals, participants added, should include an expanded focus on front-line healthcare workers as well as other key stakeholders such as patient groups and governments.

Recommendations Relating to Plans and Priorities

- That the CPSI further engage its voting members, on an ongoing basis, in defining its goals and priorities, the appropriateness of the balance between the scope and depth of its activities, and evaluating the progress accomplished in achieving its goals and overall mission and purpose. This should lead to the identification of more focused overarching, patient-centered themes under which the organization’s objectives, strategies and tactics can be organized.

Processes:

Participants in all three modes of the evaluation had high praise for the Institute's success in securing broad partnerships and team building. The organization has gathered together an impressive list of partners and managed to steer clear of jurisdictional issues – no small feat in a complex federation such as ours. The Institute's ability to leverage existing programs (i.e. the 100,000 Lives initiative in the US and the Halifax series of meetings on patient safety here in Canada) was also applauded; these allowed the organization to quickly and effectively put patient safety on the agenda in this country.

The evaluation process yielded three important recommendations for the second half of the Institute's first term: (a) focus even more on engaging the leaders in the healthcare sector, whose support often lags behind that of their front-line workers; (b) remain focused on becoming a valued repository for best practices in standard operating procedures rather than attempting to become a standard setting organization; and (c) play an important monitoring role for patient safety in Canada by becoming a repository of essential patient safety data and information without becoming a data collector.

Recommendations Relating to Process

- That CPSI initiatives be launched with a defined lifespan, baseline data and specific monitoring requirements for itself, and for its partners and the overall collaborative process, when that is the case.
- That increased funding be secured from Health Canada and that new sources of funding be secured, to allow for disciplined expansion of its activity (the termination of some, the development of new, the maintenance of progressively successful activities) now that it has been quite remarkably launched and established as a pan-Canadian resource.
- That the CPSI expand its focus to include front-line providers, patients and consumers.
- That CPSI create more of a culture of engagement with members, fostering two-way communication between CPSI and its member organizations and tapping more effectively into the resource these members represent.

Outcomes/Outputs:

Several key outcomes and outputs of the Institute's first 2½ years were singled out for mention by participants in all modes of the evaluation. Chief among these was the accomplishment of setting up a new organization "from the ground up" and assuming an important and visible leadership role in the Canadian healthcare system. While several specific initiatives received praise, the *Safer Healthcare Now!* initiative was perhaps most consistently pointed out by participants, who lauded the growing network of partners and the ability of the initiative to "put patient safety on the agenda" for a growing number of healthcare providers.

Other important outcomes and outputs that were mentioned numerous times included the Institute's research funding, its contributions to the Halifax meetings (and to making these more accessible via web casting), Canadian Patient Safety Week and other awareness-building activities such as media relations. In addition, the many protocols and standard operating procedure recommendations made by the Institute (i.e. Root Cause Analysis framework, hand hygiene) were also valuable to many participants in the evaluation process.

Recommendations Relating to Outcomes and Outputs

- That the CPSI establish its role as a critical repository of essential patient safety or patient safety related data and information, and not as a data collector, an activity best left to organizations that have this specific mandate
- That the CPSI clearly define its role in quality improvement and the relationship it intends to develop and sustain in relation to federal/provincial/territorial regulatory processes
- That the CPSI establish its role as an enabler and facilitator of standard development, definition, application and monitoring – not as a standard setting organization
- That CPSI increase its efforts to communicate about itself, enhancing the effectiveness and penetration of its messaging about patient safety.

Impacts:

While most participants agreed that it is perhaps too soon to assess the actual impacts of the Institute (as these emerge in the longer term), the consensus was clear that the Institute can take credit at this early stage for two key impacts. First, in a relatively short period of time, funding has been secured and a well managed organization has been established and given immediate momentum. Second, patient safety has been placed on the agenda at a time when Canada's healthcare system was also focused on waiting times, cost containment, human resources and other pressing issues. With these impacts as a foundation and with a solid program of processes, outcomes and outputs in place, the future impacts of the Institute should be numerous and strong.

Indeed, when asked if the Institute was meeting its goal of providing leadership, if its programs were well designed, well delivered and generated a noticeable impact, respondents to the on-line survey rated their level of agreement at 3.84 on a scale of 1 to 5. Clearly there is strong support all around for the progress made to date on this important mandate and excitement for the future of the Institute.

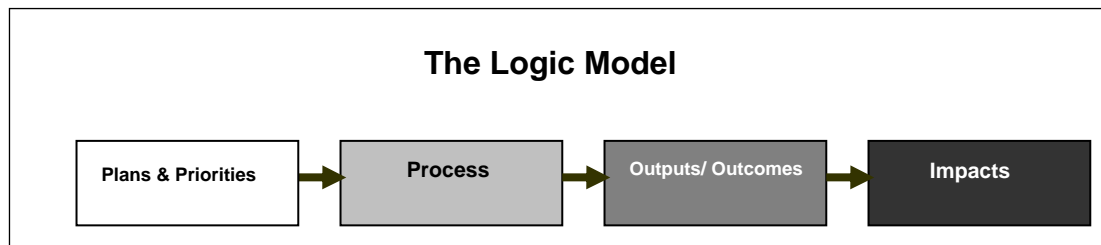
1.0 Introduction

In September 2001, The Royal College of Physicians and Surgeons of Canada determined the need for a coordinated strategy on improving patient safety within Canada. Canada's Ministers of Health established the Canadian Patient Safety Institute (CPSI) in 2003 as an independent, not-for-profit corporation, operating collaboratively with health professionals and organizations, regulatory bodies and governments to build and advance a safer healthcare system for Canadians. CPSI performs a coordinating and leadership role across health sectors and systems, promotes leading practices and raises awareness with stakeholders, patients and the general public about patient safety.

The Canadian Patient Safety Institute (CPSI) mandated Sharon Sholzberg-Gray, President and CEO, the Canadian Healthcare Association (vice-chair), and Michel Brazeau, Director of Professional Services and Medical Affairs, Gatineau Centre for Health and Social Services, and Chair of the Sponsors' Table for Human Research Participant Protection in Canada (chair), to carry out a critical evaluation of CPSI achievements and progress in relation to its mission, goals and values, halfway through its first five year term, and recommend adjustments to its practices and strategic directions. The report is to be presented to the CEO and Board of CPSI, and may, at the CPSI's discretion, be presented to its members. As background information, Sharon and Michel were both very actively involved in supporting the work of the Patient Safety Steering Committee and Working Groups that led to the creation of the CPSI, and, in collaboration with legal advisor Wayne Warren, they developed the Act of Incorporation and the initial Bylaws that were presented to and adopted by the founders of CPSI.

Approach: The Logic Model

The CPSI relies on The Logic Model for planning and evaluation. The Logic Model provides a framework for an organization that seeks to plan, implement and evaluate an effort to affect change and achieve its priorities. The framework breaks the process down into four component parts, beginning with the plans and priorities that guide the organization as it seeks to realize its vision and mission. The second component, the process, includes consideration of the resources invested by the organization, the way in which those resources are put to work and the stakeholders it engages. In the short term, this process generates the third component of the model – the outputs and outcomes of the organization, including products, services and activities. These, in turn, generate the fourth component – the long-term impact of the organization on its environment and on the behaviour of its stakeholders,



As a framework for evaluation, the Logic Model prompts organizations to examine all four components:

1. The clarity and thoroughness of the plans and priorities and how closely these align with the organization's mission and vision
2. The effectiveness of the processes, including the adequacy of resources, efficiency with which they are leveraged, and the extent to which the optimal stakeholders are engaged
3. The extent to which specific and measurable outputs and outcomes are generated in the near and middle term, according to defined timelines
4. The extent to which specific and measurable impacts are generated in the longer term and the extent to which these truly realize the vision and mission of the organization

The Logic Model consequently guided the evaluators in all aspects of the evaluation process. First, an evaluation framework (see Appendix 1) was developed on the basis of the Model and of a review of documentation relative to CPSI structure, dynamics, strategic planning, operations and achievements. The evaluation process then proceeded in three phases:

1. A brief electronic survey was derived from the evaluation framework and distributed to CPSI members and healthcare

associations. The report of findings from the survey is included in section 2.0 of this report.

2. The chairs obtained critical input from an interprofessional review panel brought together for an evaluation workshop held at the Toronto Airport Hilton on Monday, November 13th. A full report of the workshop is included in section 3.0 of this report.
3. In addition, participants in the on-line survey were invited to participate in a more elaborate structured interview with Sharon or Michel, also derived from the framework. Representatives of the major funder, Health Canada, were also interviewed on the basis of the evaluation framework, accrued results, and funding perspectives for the future. A report of findings from the interviews is included as section 5.0 of this report.

2.0 Findings: Survey

Vision Research Inc. was retained by Dr. Michel Brazeau and Sharon Sholzberg-Gray to assist with their initial evaluation of the Canadian Patient Safety Institute. The tables below summarize the findings from a small-scale survey of both CPSI member organizations (75) and a sample (225) of other healthcare organizations across the country. The survey was conducted using both mailed questionnaires and an on-line questionnaire during October 2006.

2.1 Demographic Profile

Respondents were fairly balanced between regions of the country, though we note that representation from the Atlantic provinces and Quebec was small. Of the 71 respondents, 43 (60.6%) represented front-line healthcare providers, reflecting the overall membership of the CPSI.

Q1. In which province is your organization primarily located?	Number	Percent	Q2. Is your organization a front-line healthcare provider?	Number	Percent
Alberta	7	9.9%	Yes	43	60.6%
British Columbia	11	15.5%	No	28	39.4%
Manitoba	6	8.5%			
Nunavut	0	0.0%			
New Brunswick	0	0.0%			
Northwest Territories	1	1.4%			
Nova Scotia	3	4.2%			
Newfoundland and Labrador	0	0.0%			
Ontario	39	54.9%			
Prince Edward Island	1	1.4%			
Quebec	2	2.8%			
Saskatchewan	1	1.4%			
Yukon Territory	0	0.0%			
TOTAL	71	100%			

For reasons of confidentiality, no more specific breakdown of the respondent profile can be presented.

2.2 Evaluation

Respondents were asked to rate a number of aspects of the outputs, outcomes and impacts of the CPSI at this mid-way point of its first cycle. The responses were quite positive, with an average rating of 3.84 on a scale of 1 to 5, where 5 represents strong agreement with a series of positive statements. Indeed, on three of the five questions posed to all respondents, none of the respondents indicated they disagreed strongly with the statement.

Q3. In the space provided, please circle the number that best represents your level of agreement or disagreement with the following statements.							
Statement	Disagree Strongly			Agree Strongly		Don't Know	Average *
	1	2	3	4	5		
a) The services of the Canadian Patient Safety Institute (CPSI) are well-designed.	0	4	14	31	6	16	3.7
b) The Canadian Patient Safety Institute (CPSI) is meeting its goal to provide leadership with respect to patient safety issues in the context of improving healthcare quality in Canada.	1	4	13	27	13	13	3.8
c) There is a continuing need for investment in programs and initiatives, advocacy and services relating to patient safety in Canada.	0	0	1	15	54	1	4.8
d) The Canadian Patient Safety Institute (CPSI) has had a noticeable impact on health and healthcare in Canada relative to its mandate.	3	5	19	23	3	18	3.3
e) The services of the Canadian Patient Safety Institute (CPSI) are well-delivered.	0	4	21	25	5	16	3.6
Question asked of front line respondents only							
f) The Canadian Patient Safety Institute (CPSI) has had a noticeable impact on our own organization's activities in the area of patient safety.	7	5	4	19	4	4	3.2

* Average score from those respondents who circled a number and not those who selected "Don't know."

2.3 Accomplishments

Participants were next asked to identify up to three specific accomplishments in enhancing patient safety that they felt were attributable to CPSI. They were asked to list these advances in order of importance. The accomplishments they cited are listed below, and organized by the rank respondents gave to each accomplishment (from most important to third-most important).

The results point to the high regard among participants for the ***Safer Healthcare Now!*** initiative, which was selected as the #1 accomplishment by a majority of participants. As one respondent expressed it:

CPSI has spearheaded the *Safer Healthcare Now!* Campaign and has been supporting it nationally. The importance of this initiative will be to provide solid data to show that where patient safety processes are applied, real and measured improvements can be made.

A number of respondents pointed to specific **protocols and recommendations** by the CPSI as the #1 accomplishment from their perspective. Specific topics such as surgical site infection protocols, Look-Alike-Sound-Alike (LASA) notifications, and hand hygiene were singled out by these respondents.

Many respondents also pointed to the CPSI's many efforts to **raise awareness** among healthcare workers, governments and the public of patient safety issues as its #1 or #2 accomplishment. Canadian Patient Safety Week and the Institute's website were often cited as examples of success in this endeavour.

The CPSI's efforts to **fund research** into patient safety were also recognized as a #1 or #2 accomplishment by many respondents. Said one respondent on the importance of this catalytic funding:

While the results are not yet in, CPSI made available significant funds for research related to various aspects of patient safety. Much of this research may not have been possible without this CPSI initiative.

The Institute's success in developing a national **network of partners** dedicated to enhancing patient safety was also a common theme in the responses. As one respondent from Quebec expressed it, the Institute has been able to gather together individuals who have an interest in patient safety (« un effet rassembleur de tous ceux qui s'intéressent à la sécurité des soins »). The Institute's contribution to the Halifax 6 Conference was often cited as a concrete and important example of this effect.

Many other specific programs and initiatives were singled out as significant accomplishments by participants. All responses to this question are gathered together and sorted in Appendix 2 of this report.

3.0 Findings: Evaluation Workshop

3.1 Introduction

On November 13, in Toronto, Ontario, the CPSI Initial Evaluation Workshop brought together a number of participants from different healthcare settings to reflect on the performance of the Canadian Patient Safety Institute mid-way through its first term. Present at the one-day workshop were the following individuals:

Michel Brazeau, MD, FRCPC
Co-Lead Evaluator
Director, Professional Services & Medical Affairs
Centre de santé et de services sociaux de Gatineau

Barb Mildon, RN, MN, CHE, CCHN(c)
Chief Nurse Executive and Vice President, Professional Practice and Integration
Fraser Health

Sharon Sholzberg-Gray
Co-Lead Evaluator
President and CEO
Canadian Healthcare Association

Linda Poloway, BScPharm, FCSHP
Coordinator, Patient Safety
David Thompson Health Region

Ben Chan, MD, MPH, MPA
Chief Executive Officer
Saskatchewan Health Quality Council

Dr. Ian White, MB, FRCPC
Chief of Anesthesia
William Osler Health Centre

Joining the participants to present the findings of the initial evaluation survey (which his firm had been retained to conduct) and to assist with preparing this report was Bernard Gauthier, MA, President of Vision Research.

The discussion was largely free flowing, with some structured questions discussed. At the close of the workshop, participants focused on a list of recommendations built around the day's discussion. Workshop participants were also provided with brief presentations of the results of the survey and a summary of the main findings emerging from the structured interviews completed at that time.

This report is based on a content analysis of the day's discussion. To give structure to the content, the various discussion points were grouped into four key categories, corresponding to the key elements of the Logic Model approach to planning, implementation and evaluation:

1. Plans and Priorities of the CPSI
2. Processes (the key inputs, how they are processed and what stakeholders are engaged)
3. Outputs and outcomes (the tangible products and services provided by the CPSI and the short-term outcomes they generate)
4. Impact (the longer-term changes in behaviour, adverse event incidence and health outcomes generated by the CPSI)

3.2 Plans and Priorities

This first component of the Logic Model generated considerable discussion throughout the entire day. Note that a summary of the Institute's Business Plan is contained in Appendix 3 of this document and contains several elements which are referred to below. Four principle themes emerged in this discussion.

A Vital Mandate, an Impressive Start

Participants in the workshop were unanimous in their support for CPSI and on the need for continued funding. The mandate is recognized by all as a vital one.

Participants also recognized that the CPSI is a new organization and, as such, the wide range of priorities with which it set out is reflective of an appropriate flexibility and experimentation at the outset of its mandate.

Time for More Focused and Integrated Goals

Participants understood that the mandate of the CPSI and the political context in which it operates make it difficult to articulate targets that may be perceived as operational. Participants also applauded the Institute's "softer" goals, such as linkages, definitions and partnerships and recognized that these are important in their own right.

Moving forward, the group called for CPSI to more clearly state and tightly focus its goals, along with setting firmer targets. The feeling shared by many around the table is that the organization needs to set and state goals in ways that are clear, meaningful and tied to a compelling overall mission that is widely known to leaders outside the "core" of the patient safety community – a *raison d'être*.

In addition, participants agreed that henceforth, the CPSI's goals should include aggressive and measurable targets, in the style of the IHI's campaign to save 100,000 lives. Firm targets that involve both measurable results and fixed deadlines, the group felt, would do more to galvanize *leaders* throughout the healthcare system and would allow for more effective evaluation of the Institute at the end of its first term. With the current goals, there is, as one participant expressed it, "no pressure on CEOs to pay attention."

Participants also called attention to the number and breadth of Key Priorities contained in the CPSI Business Plan. They called for greater integration of a smaller number of key priorities under a few carefully defined themes, such that success in one key priority area advances the others.

On a similar note, several participants called for specific measurable objectives tied to each of the identified key priorities. As it stands, the "perspectives" for measurement cited in the Business Plan (i.e. Customer

Focus, Value Creation) can't immediately be traced to specific key priorities. The lack of measurable objectives for each key priority also made it difficult for participants to comment on the extent to which the key priorities are realistic and, fundamentally, the extent to which they are currently being met. Pointing to a list of the CPSI's key priorities, one participant summed up their position as: "Each of these could be measured, counted and monitored."

A second concern raised with the measurement framework was the lack of baseline data on which to base a measure of progress. Had such baseline data on areas such as patient safety culture been gathered as the CPSI set out on its mandate, the task of evaluating performance would be easier and more revealing.

An Expanded Focus for the Future

A second theme that emerged in the workshop was the need for CPSI to consider a slight change to its focus for the future. The group felt that the current focus on hospitals and physicians needs to be expanded now to include other care settings (notably long-term care) and health professions, and that greater focus be put on the role of consumers in patient safety.

The group agreed that the CPSI is right to support the development of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) as one of its key priorities. The maintenance of the database, in the group's opinion, should not become a core responsibility of CPSI.

3.3 Processes

Most of the discussion for the day was reserved for the "Processes" aspect of the CPSI's performance. Participants identified many strengths in the processes at work and made specific recommendations for improvements and for building on those strengths.

Partnerships and Team Building

The partnerships established by the CPSI emerged as one of the key strengths of the organization as assessed by the workshop participants. Participants lauded the quality of the partnerships in place, how well they are functioning, and the speed with which many of these were established. "Their ability to establish national teams so quickly was impressive," as one participant summed up.

There was also praise for the ability of the CPSI to steer clear of federal/provincial/territorial "traps" by avoiding operational decisions, focusing on partnership and doing a good job of securing input (i.e. roundtables in provinces, regular meetings with CEO and management, etc.). Many participants pointed to *Safer Healthcare Now!* as a particularly strong example of people from many regions working together towards the same cause.

Indeed, the group called on the CPSI to make even better use of volunteers, as a way to increase capacity on an ad hoc and adjustable basis. By tapping more fully into its membership, the Institute can engage these groups more and enhance their ability to act as ambassadors for CPSI. This call for engagement extends to the CPSI's 73 members, with one participant noting that only 18 of those members sent a representative to the Annual Members Meeting. All members should realize they are, in effect, the shareholders of the Institute and have a role to play in influencing its future.

Praise for Specific Initiatives

Participants had praise for many of the specific processes initiated by the Institute up until now. Specific initiatives that were cited include Safer Healthcare Now! (as mentioned above), the Halifax series of meetings (and efforts to make them accessible through webcasting), research funding (and especially the efforts to bring research to the front lines of healthcare delivery), curriculum development, the disclosure initiative, the Root Cause Analysis Framework, and the CEO meetings. Many also praised the efforts of the senior management of the organization to be visible and accessible, ensuring good relations with stakeholders and members. The group called on CPSI to build on the success of the many initiatives which duplicated or carried over from other organizations and to focus future efforts on initiatives that were truly its own.

Focus on Leaders in the Healthcare Sector

Many participants noted that the success of the Institute in engaging partners and building teams does not always extend upwards to the executive suite. They perceive a lack of both commitment and engagement of CEOs that makes it easier for organizations to opt out and makes it more difficult to drive changes through the entire organization. "The CEO's in the institutions," explained one participant, "have to become stronger champions."

Repository for Best Practices in SOPs vs. Standard Setter

All participants agreed that the CPSI has a role to play in championing the adoption of best practices in patient safety throughout the country. Many participants called for the CPSI to gather and become a repository for best practices in standard operating procedures, in so doing becoming a centre of excellence.

Where there was less agreement, however, was on the question of extending the centre of excellence role to become a standard setter. While some saw it as a natural role for the CPSI (especially in the longer term), others cautioned that the CPSI can't be operational and must limit its role to being a champion, given the political environment in which it operates. Still others questioned if the CPSI should become a repository (as opposed to supporting

and providing guidance to a repository), as other organizations are already set up to gather, store and share data. Consensus did emerge on the recommendation that the CPSI consider becoming a standard setter in the long run, on standards specifically linked to patient safety.

Monitoring Role

A similarly wide ranging discussion also centered on the question of the role of the CPSI as a Canadian monitoring and reporting agency for adverse events. The group agreed that monitoring and reporting on adverse events in Canada are outside the mandate of the organization but that the CPSI should have a role to play as a champion, ensuring that data is indeed gathered but without actually gathering and holding it. Participants also agreed that the Institute should have an important role in monitoring other indicators of progress, such as the degree to which infrastructure is going into place in institutions, international best practices in patient safety, monitoring the impact of their own and other patient safety initiatives and, as mentioned, monitoring best practices as they emerge.

Management and Administration

Finally, a good deal of discussion in the area of Processes focused on the management and administration of the organization. Participants praised the founders of the Institute for their ability to communicate, share and organize “virtually,” making full and cost-effective use of telephone and internet technology. Participants called for continued commitment to the notion of building an institution without walls and making full use of technology to increase the reach and capacity of the organization without necessarily increasing its size. The group also noted that many of the CPSI’s activities are shared and, thanks to the participation of other levels of government, the initial investment of the Institute is often multiplied as much as ten-fold. Citing anecdotal evidence, participants called on CPSI to ensure an appropriate ratio of staff to *Safer Healthcare Now!* teams to ensure these important teams are supported, trained and nurtured so they can deliver optimal results.

3.4 Outputs and Outcomes

Participants identified both a number of outputs and outcomes that are worthy of praise and a number of new outputs and outcomes for the CPSI to consider as it moves forward into the second half of its mandate.

Leadership and Visibility

To begin with, participants in the workshop agreed that the CPSI is providing evident leadership in patient safety. Participants applauded CPSI for its ability to establish a strong leadership position so early in its mandate and so soon after having set up an office and hired permanent staff. Participants agreed that CPSI has played an important role in “putting patient safety on

the agenda for leaders in the system” and making it “a focus with staff resources.” Many participants also praised the Institute for the high profile it, its leaders (notably CEO Phil Hassen) and its programs (i.e. Root Cause Analysis, *Safer Healthcare Now!*) have assumed in the community and in the media. “They’re packaging well, getting out and presenting well,” summed up one participant.

For the future, participants called on CPSI to further improve its communication so as to be truly “top of mind” among stakeholders in the healthcare community. Participants also called on the Institute to gather specific evidence that efforts to reach out and engage stakeholders are effective (i.e. number of times quoted in media, number of participants at events).

Research Funding

The funding of targeted research projects in the area of patient safety was described as “the key output” of the Institute. Participants agreed that the projects selected for funding were pursuing the right questions and built around the right themes and appreciated that progress on research funding could be measured using specific dollar figures and timelines.

Participants also agreed that it was still too early to tell what the eventual outcomes from these research projects will be. As results of the studies are published, the Institute will be in a better position to determine to what extent the output has changed the research landscapes and advanced the cause of patient safety in Canada.

Safer Healthcare Now!

The *Safer Healthcare Now!* initiative (SHN) was also identified as an evident and positive output from the CPSI. SHN was praised for the amount of on the ground support and participation it has generated and the Institute was praised as the body that maintained SHN and moved it forward.

The group recognized that the framework for the SHN program was built on the IHI model in the US and praised the Institute for making full use of the model as a way to launch a campaign quickly and cost-effectively.

Halifax 6

The Halifax series of conferences on patient safety was also singled out as “a real strength of the Institute.” Participants agreed that CPSI’s visibility and status has grown with each meeting and that their impact was readily felt at Halifax 6. Participants again praised the CPSI for its efforts to make the meetings accessible via video conference, allowing more people to “attend” in spite of limited budgets. Participants at the workshop also welcomed the overall message of Halifax 6 (patients in patient safety), though noting that the message was received “coolly” in some areas and will need to be moved forward carefully.

Other Outputs and Outcomes of Note

Other outputs of the CPSI that were singled out for praise by participants in the workshop include the knowledge translation efforts, promotion of the PDSA Model (plan, do, study, act), and the efforts to engage leaders in healthcare at the Kananaskis meetings. These received considerable praise from the workshop participants, with some calling for an expansion of this effort to reach out to professional as well as administrative leaders, working with the major professional associations in the country. The group agreed that the focus on engaging leaders in the healthcare sector is “the right direction” though the full measure of this important output is not possible at this early stage.

New Outputs and Outcomes to Consider

Participants in the workshop also suggested new outputs for the CPSI to consider in the future. Chief among these was an effort to integrate patient safety curriculum into healthcare education in an effort to change foster a culture of safety among students (as the foundation for future practitioners). Participants called for patient safety to be “a thread throughout the curricula, and not limited to isolated courses or workshops.” In particular, participants called for greater use of simulation in teaching and learning in a team environment that reflects the work environment. As one participant explained, “We organize medical education in silos and then expect people to move into a team environment and function there.” Participants agreed that the CPSI can and should seize the opportunity to play a leadership role, providing guidance to other organizations that set educational standards and curricula (both in Canada and the US).

A second suggestion for new outputs which drew considerable discussion was for the CPSI to publish a directory of healthcare organizations and their structure – how each handles patient safety, and how patient safety initiatives are funded. Such a publication would allow for comparing and contrasting approaches to patient safety in different organizations and jurisdictions and perhaps spur healthy competition to promote change. The group acknowledged, however, that such a publication could provoke resistance from jurisdictions and organizations that don’t compare favourably in terms of the resources they are investing in patient safety.

3.5 Impacts

Putting Patient Safety on the Agenda

Participants in the workshop, as noted earlier, agreed that the most important impact of the CPSI’s work to date has been to put patient safety on the agenda of organizations throughout the healthcare sector. Particularly impressive is that patient safety has been made a priority at a time when the country has been focused on quantity of healthcare, more so than quality

(i.e. wait times). For the second half of its first term, the group called on CPSI to focus on leveraging this initial support to catalyze real and enduring change in healthcare delivery. As one participant asked rhetorically, “The political commitment is growing but are they just saying it? Are they dedicating actual resources?” Measuring the true impact of this effort to put patient safety on the agenda means moving beyond measures of how many organizations have signed on, to assess how many have changed the way they deliver healthcare.

Multiple Factors

While acknowledging and praising the work of the Institute for putting patient safety on the agenda in this country, participants also noted that linking that overall impact to specific outcomes or processes is made difficult by the fact that so many organizations and factors can be traced to this impact.

Participants cited a number of reasons why they feel patient safety has become a priority in Canada, including the Baker-Norton study, the IHI’s 100K Lives campaign in the US, world-wide attention to patient safety as a result of WHO efforts, JACO, CPSI and the CCHSA’s efforts to review its standards for patient safety in its accreditation process. In short, respondents acknowledged that CPSI has had an impact but it is often an indirect and catalytic impact and hard to measure with certainty. Nonetheless, participants agreed strongly that the CPSI is one of the *key* organizations that can take credit for this change in priorities.

Too Soon to Measure Impact

Participants also expressed numerous times throughout the day that it is simply too soon to measure the impact generated by the many outputs of the CPSI. Measuring the impact of the Institute will require an infrastructure that is able to gather the relevant data and widespread agreement on what the true measures of patient safety are (i.e. standard mortality rates). Of course, research and leadership will be required to arrive at the optimal measures – a role the CPSI could well fill in the future. “At this point, we don’t have any way of measuring,” summed up one participant. The focus of the group, then, was on identifying what data currently is available that could serve as a useful measure of impact, and what data need to be gathered in the next two years so that a full measure of the CPSI’s impact will be possible at the end of its first term.

Available Indicators of Impact

Participants in the workshop suggested a number of readily available measures that should be taken to assess the impact of the CPSI in the longer term. These are listed below in no particular order:

- Amount of money invested in research related to patient safety across Canada
- Number of people trained in patient safety issues

- Number of organizations that have at least one team participating in Safer Healthcare Now!
- Number of specific changes to procedures and policies that respond to recommendations of the CPSI (e.g. removing concentrated KCI)
- Number of research projects that have received funding from CPSI
- Number of people who attend (or virtually attend) CPSI learning events across the country
- Number of organizations that have included patient safety measures and issues in their strategic plans
- Number of root cause analyses conducted that have been based on CPSI training and framework
- Number of articles on patient safety research that are authored by Canadian researchers and that are published in peer-reviewed journals

Measurements Needed

Participants also identified measures that are not currently available and that should be put in place as the CPSI approaches the end of its first term. The focus here was on the need for baseline measures and on the need to determine the extent to which patient safety impacts can be attributed to the CPSI's outputs, as compared to other players in patient safety.

- Increase in levels of awareness and understanding of patient safety issues and of CPSI initiatives (requires a baseline measurement to be taken)
- Number of organizations that report specific changes made to procedures and policies as a result of training and leadership by CPSI, as opposed to other key players in patient safety
- Continual monitoring and measuring of the incidence of adverse events in Canadian healthcare delivery settings (i.e. Baker-Norton on a permanent basis)
- Number of identified patient safety champions in healthcare organizations as compared to the total number of people within the organization (With the target number of patient safety champions being equal to the square root of healthcare professionals within the organization)

4.0 Findings: Executive Interviews

4.1 Introduction

As part of the Initial Evaluation process, a series of structured interviews were conducted by either Sharon Sholzberg-Gray or Michel Brazeau with a total of 30 respondents from 28 organizations. The respondents all volunteered to participate. The duration of the interviews was strictly limited to 20 minutes. The respondents were asked to support their answers, as much as possible, with relevant data or examples. They were assured the information that was gathered would be treated as confidential and reported in aggregate format with no link to the respondent's identity. A summary overview of CPSI, prepared by CPSI was offered at the time of the survey and, again, in preparation for the interviews.

A summary of the responses appears below. The pattern of responses is qualified as "S" when they occur in a standard distribution across a broad spectrum; as "M" when they occur as two or more groupings; and as "C" when a consensus occurs among the respondents.

4.2 Findings

The interviewers found that the answers to the questions they posed in the executive interviews fell into one of three categories: those on which there was wide agreement and **consensus** among all participants; questions which showed a **standard deviation**, with the majority of participants in agreement and a minority split on the issue; and those questions on which participants were **evenly split** into two or more groupings. The questions and responses are organized into these three categories below.

A. Questions on which there is Consensus

Is the CPSI meeting its goal?

Overall, respondents agreed that the answer is "yes." CPSI is recognized for providing leadership and coordination, raising awareness about patient safety, and launching important and successful initiatives that build on partnerships and the success of others. The latter phenomenon is placed in a positive light but the point is made that it is difficult to assess the contribution of each partner and the hope is expressed that CPSI will also attempt to innovate.

What specific advances in patient safety are attributable to CPSI?

Respondents cite a wide array of CPSI accomplishments, attribute a different value to each, but note there are no metrics to demonstrate CPSI causality for any advances.

What leverage have investments in CPSI had in advancing the development of knowledge and research in the areas of patient safety?

CPSI was given high marks by respondents for its capacity building in the area of research. Participants expressed hope that this research will, in turn, lead to the development and application of knowledge, though some cautioned that it is too early to measure these effects.

Are patients safer today than they were before the formation of CPSI?

Respondents agreed that it is too early in the CPSI's mandate to tell to what extent Canadian patients are safer. They cautioned that, though standardized mortality data may be suggestive, as a sole indicator, it should not be relied upon to make this claim.

Have investments in CPSI resulted in a decrease in unintended adverse events?

There was a clear consensus among respondents here that there is no supportive evidence at this early stage and that they cannot answer the question as a result.

Is the program and service delivery of CPSI attractive, effective and engaging?

There was consensus around the fact that the delivery of the CPSI's programs and services is attractive, effective and engaging. In this sense, the sense of "clubbiness" was viewed as a positive. For the future, participants recommended an even greater effort at outreach into the national healthcare community.

B. Questions on which there is Standard Deviation

Is the quality of deliverables generated by CPSI improving over time?

A majority of respondents answered "yes" to this question, with a minority indicating they "don't know" or that it was simply "too early to tell."

What progress has been made in achieving CPSI's mandate and goals?

Respondents refer to varying CPSI accomplishments and describe progress as good to outstanding. Suggestions include developing an improved

hierarchy and correlation framework of CPSI initiatives, focusing more on systems and less on sectors, increasing CPSI involvement in community, long-term care and gerontology, continuing to assume a very active role as a “culture carrier,” and continuing to provide the critical support needed by the mid and smaller size health and healthcare organizations involved in patient safety.

What is CPSI's most remarkable achievement?

Many respondents pointed to specific achievements such as *Safer Healthcare Now!*, Canadian Patient Safety Week, the Halifax 6 Conference and the effective use of advisory groups. Others spoke about key achievements that brought about a change in the operating environment, such as generating higher levels of awareness about patient safety issues, initiating a culture change, demonstrating leadership, securing the required funding, and getting off the ground effectively in a short period of time.

What is CPSI'S greatest shortcoming?

Respondents offered a wide range of answers to this question, including a lack of balance between breadth and depth, a lack of clear purpose for the organization, as well as insufficient self-promotion and outreach to providers, patients and the public. Other respondents cited the lack of progress on implementing a national reporting system, inadequate communication, and a focus on physicians that is either too physician centric or not physician centric enough. Finally, some lamented that the CPSI, in their view, remains essentially a federal institution.

Is there a unique goal, objective or duty that obviously needs to be added to the CPSI program of activities?

Respondents had various suggestions for the addition of goals, objectives or duties, such as improving the monitoring of patient safety data, identifying and featuring champions of specific patient safety causes, paying more attention to home care, community care, long-term care and mental health, along with focusing more on the practices required for accreditation.

C. Questions on which Participants were Split

What leverage have investments in CPSI had in helping healthcare organizations, providers and healthcare consumers in improving patient safety?

Respondents pointed to numerous ways in which investments in CPSI have been leveraged, including raised awareness, partnerships, education and tools (including standardized terminology), support for other organizations, and, to a lesser extent, providers. One point of leverage which was found to be lacking was direct reach to consumers. Overall, CPSI activity was seen by

respondents to be directly leveraging funding from the provinces and indirectly leveraging funding from those healthcare providers that are participating in CPSI and other patient safety activities. A minority of respondents indicated the “don’t know” the answer to this question.

Has the investment in CPSI resulted in an increased understanding of patient safety issues at the institutional, provincial/territorial and caregiver levels?

A strong majority of respondents answered “yes” to this question, with a minority indicating the “don’t know” at this point. Participants suggested the answer likely varies from organization to organization and from community to community. Canada’s western provinces are perceived to be in the lead in this regard. Respondents cited Canadian Patient Safety Week, *Safer Healthcare Now!*, the Halifax conferences and other patient safety activities as evidence that this increased understanding is occurring.

What have been the impacts to date and what impacts are likely in the future related to CPSI and its mandate?

Respondents focused on heightened awareness, encouraging momentum in terms of changed behaviour, and the fostering of interprofessional collaborative practices. A minority of respondents indicated they “don’t know” at this point, citing a lack of national data to support the claim of specific impact. Respondents agreed that ensuring a positive impact on regulatory processes should be a target for the future.

Given the CPSI's goals and objectives, are the organization's services, programs and initiatives appropriate?

A majority of respondents agreed that the services, programs and initiatives of the CPSI are indeed appropriate. A substantial minority of respondents, however, questioned the balance between breadth and depth in referring to CPSI activities. Some of these called for a broadened scope, while others argued for greater depth and focus. An emerging “clubbiness” was identified as a risk not to be taken lightly by the CPSI. Those who cited the risk called for greater outreach to counter the trend.

Is the CPSI effectively engaging the stakeholders it set out to engage?

A majority of respondents see the members as “shareholders” and seek greater engagement of members by the CPSI as well as greater accountability to them. Respondents argued that the level of communication with all members is insufficient and that the reliance on the AGM for “rubber stamping” is inadequate. Respondents also called for greater engagement of the provinces and the development of province-specific frameworks, foci and themes in dealing with patient safety issues. Respondents also argued that

patient safety should be a common thread throughout healthcare education. A minority of respondents simply responded “yes” to this question.

Are there other important stakeholders that need to be added to the list in order for the organization to be successful?

A majority of respondents called more attention to front-line healthcare providers, patients, the public, and CEOs. Respondents also argued that the CPSI must add to its list of stakeholder: regulatory agencies, organizations that represent cultural diversity relative to healthcare, and organizations that can improve data monitoring relative to patient safety.

5.0 Recommendations

The following recommendations stem from all aspects of the evaluation work undertaken in the preparation of the report. The recommendations were agreed to by all participants in the workshop and are presented below in order to the Logic Model element to which they belong.

5.1 Plans and Priorities

- That the CPSI further engage its voting members, on an ongoing basis, in defining its goals and priorities, the appropriateness of the balance between the scope and depth of its activities, and evaluating the progress accomplished in achieving its goals and overall mission and purpose. This should lead to the identification of more focused overarching, patient-centered themes under which the organization's objectives, strategies and tactics can be organized.

5.2 Process

- That CPSI initiatives be launched with a defined lifespan, baseline data and specific monitoring requirements for itself, and for its partners and the overall collaborative process, when that is the case
- That increased funding be secured from Health Canada, and that new sources be secured to allow for the disciplined expansion of CPSI activities (the termination of some, the development of new, the maintenance of progressively successful activities) now that it has been quite remarkably launched and established as a pan-Canadian resource
- That the CPSI expand its focus to include front-line providers, patients and consumers
- That CPSI create more of a culture of engagement with members, fostering two-way communication between CPSI and its member organizations and tapping more effectively into the resource these members represent.

5.3 Outputs and Outcomes

- That the CPSI establish its role as a critical repository of essential patient safety or patient safety related data and information, and not as a data collector, an activity best left to organizations that have this specific mandate
- That the CPSI clearly define its role in quality improvement and the relationship it intends to develop and sustain in relation to federal/provincial/territorial regulatory processes

- That the CPSI establish its role as an enabler and facilitator of standard development, definition, application and monitoring – not as a standard setting organization
- That CPSI increase its efforts to communicate about itself, enhancing the effectiveness and penetration of its messaging about patient safety.

6.0 Appendices

Appendix 1: Evaluation Framework

Appendix 2: Summary of the CPSI Strategic Business Plan

Appendix 3: Specific responses to on-line survey question on accomplishments

Appendix 1: Evaluation Framework

Evaluation Issues, Questions, Performance Indicators and Data Methods

Background

In this evaluation framework, a significant range of evaluation issues and questions is identified. The broad coverage of issues ensures that the framework will be applicable to the various initiatives supported by CPSI and be the basis for the identification of meaningful questions and performance indicators to assist in the ongoing monitoring and assessment of CPSI's progress.

Evaluation Issues and Performance Indicators

To enable ready understanding of the relationship between the evaluation issues and the corresponding performance measures, the linkages between these two evaluation components are presented in a matrix format. There are six evaluation issues, with supporting questions, listed under five headings: relevance; objectives achievement; outputs; impacts and effects; and program management and delivery. Each issue is explained in terms of its intent. For each question accompanying an issue, a performance indicator is defined which will permit assessment of that evaluation question. Also identified, are the targeted data sources (or methods) most suited for providing the information required by the indicators¹.

It should be noted that in order to assess the impact of CPSI programs, initiatives and activities, a baseline of information is required against which the changes brought about as a results of CPSI efforts can be measured. For a number of the identified performance indicators, new types of information are being sought and a baseline may not exist for the purposes of determining incremental change. In this case, measurement of any change will not be possible, but any evaluation of CPSI or of its initiatives based on the identified performance indicators will provide information that becomes the baseline for further evaluations. For some issues and questions, it is not feasible or practical to develop quantitative performance indicators. In these cases, more qualitative indicators are proposed, which generally rely on opinions or knowledgeable individuals.

It should be noted that evaluation issues and the assessment of CPSI performance should be contextualized and considered against the backdrop of resources available to CPSI and the mandate of the organization in general.

¹ For the purposes of this draft, performance indicators and data sources for review have not been identified. CPSI will work with its consultants to finalize these evaluation elements over the following days.

Evaluation Issues

Issue #1: Relevance

What is the extent of the continuing need for investment in programs and initiatives, advocacy and services relating to patient safety?

This issue and accompanying research questions examine the extent to which CPSI has successfully satisfied the requirements of governments, health system stakeholders, patients and the general public in addressing patient safety concerns and whether continuing investments in patient safety initiatives are required.

Question				Performance Indicators			
To what extent is continuing investment in patient safety services, programs and initiatives needed in Canada to reduce adverse events and medical errors?				<ul style="list-style-type: none"> ○ # of adverse events in Canada ○ Existence of a National Adverse Event Reporting System 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
What are the implications for governments, healthcare organizations and providers of continuing investment in CPSI?							
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Issue #2: Goals and Objectives Achievement

Is CPSI meeting its goal?

CPSI's mandate is to provide a leadership role with respect to patient safety issues in the context of improving health care quality.

To achieve its objectives, CPSI will work closely with governments and health system stakeholders. It will collaborate and provide advice on effective strategies to improve patient safety, coordinate information across sectors and systems, promote best practices and raise awareness with stakeholders, patients and the general public about patient safety. CPSI will play an advisory and facilitative role in the health care system, not an operational role. It will foster the sharing of knowledge and information about optimal patient safety practices and models; influence change in culture and provide advice to support change in systems to improve patient safety; and collaborate with stakeholders in an ongoing dialogue to support patient safety improvements.

Performance indicators for this issue are primarily qualitative and answers to the questions will rely mainly on interviews.

Question				Performance Indicators			
What progress has been made in achieving CPSI's mandate and goals?				The extent to which the patient safety goals of CPSI, as identified in its strategic plan, have been achieved.			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
Are CPSI's mandate and goals reasonable and realistic?				The extent to which CPSI's goals and objectives are reasonable in intent and realistic in terms of their achievability.			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
Are there un-stated objectives, in addition to those noted above, that are serviced by CPSI? Should other objectives be added?				The extent to which CPSI has helped healthcare organizations, providers and the public to reach other objectives.			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Issue #3: Outputs

What outputs have there been from investments in CPSI?

This issue focuses on the determination of short-term results of CPSI's efforts and initiatives in relation to the objectives of CPSI such as providing advice on effective strategies to improve patient safety, coordinating information across sectors and systems and promoting best practices and raising awareness with stakeholders.

Question				Performance Indicators			
What are some of the specific advances in patient safety that are attributable to CPSI?				<ul style="list-style-type: none"> ○ # of new research studies funded/underway/completed ○ Patient Safety competencies developed and incorporated into Curricula ○ Influence in legislation ○ % uptake of applicable initiatives at the provider/hospital/LTC level 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
Is the quality of deliverables generated by CPSI improving over time?				<ul style="list-style-type: none"> ○ Member and stakeholder satisfaction 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
What leverage have investments in CPSI had in helping healthcare organizations, providers and healthcare consumers in improving patient safety?				<ul style="list-style-type: none"> ○ Increased adverse event reporting ○ % uptake of initiatives (i.e. Safer Healthcare Now!) ○ # of executives trained ○ # of Patient Safety Officers Certified through CPSI 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question			Performance Indicators				
What leverage have investments in CPSI had in advancing the development of knowledge and research in the areas of patient safety?			<ul style="list-style-type: none"> ○ the extent to which the CPSI has a growing repository of current knowledge, best practices and research available to health system stakeholders and the general public ○ # of new research studies funded/underway/completed 				
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question			Performance Indicators				
Are patients safer today than they were before the formation of CPSI?			<ul style="list-style-type: none"> ○ Qualitative and quantitative indicators as reductions are reported ○ Trending, monitoring in HSMR 				
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question			Performance Indicators				
Has the investment in CPSI resulted in an increased understanding of patient safety issues at the institutional, provincial/territorial and caregiver levels?			<ul style="list-style-type: none"> ○ # of institutions and teams that have adopted some kind of reporting system ○ # of institutions and teams that have a defined patient safety function in organizational chart, and associated budget ○ # of institutions and teams that have executives trained with CPSI's executive/board session(s) 				
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question			Performance Indicators				
Have investments in CPSI resulted in a decrease in unintended adverse events?			<ul style="list-style-type: none"> ○ The extent to which the number of medical errors/adverse events have decreased in Canada based on a sampling of institutions and teams where CPSI programs and initiatives have been implemented 				
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Issue #4: Impacts and Effects

What have been the impacts to date and what impacts are likely in the future related to CPSI and its mandate?

This issue addresses the longer-term results that flow from the investment in CPSI and from the research conducted by CPSI and its partners. The results are examined in terms of the objectives of CPSI.

Question				Performance Indicators			
To be determined.							
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Issue #5: Design, Management and Delivery

Are CPSI's services well-designed and well-delivered?

This issue relates to the efficiency and effectiveness of the CPSI's internal project and management mechanisms, focusing particularly on management procedures and practices and their relative effect on the achievement of CPSI's objectives.

Question				Performance Indicators			
Given CPSI's goals and objectives, are CPSI's services, programs and initiatives appropriate?				<ul style="list-style-type: none"> ○ Do CPSI's services, programs and initiatives provide transparency to mission, vision & values? ○ # of partnerships leveraged for services, programs and initiatives 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Institutional Research Plans	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
Are criteria to review and evaluate processes present, adequate and relevant given CPSI's goals and objectives?				<ul style="list-style-type: none"> ○ Criteria developed and utilized to review and evaluate processes ○ Extent to which criteria are used to review and evaluate processes 			
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Question				Performance Indicators			
Is the program and service delivery of CPSI of high quality?							
DATA SOURCES FOR REVIEW							
Interviews			Survey	Progress Reports	Financial Reports	Committee Reports	Other
Funding Agency	Institutional	Project					

Data Sources and Methods

To adequately address these key evaluation issues and answer their respective questions, the following data sources have been identified. As well, the methods by which these data sources will be accessed and/or interviewed are also provided for review and consideration:

Data Sources	Methods
Health Canada	Interviews with Health Canada
Institutional	An electronic survey to approximately 100 individuals, 50 twenty-minute interviews
Project	Interviews/case studies with project leaders, committee members
Survey	To assess the elements defined in the proposed Scope (in CPSI Meeting notes referred to above), the survey would be proposed to all Voting Members of CPSI, all members of the Board and senior administration of CPSI, partners and collaborators of CPSI, a small sample of other organizations selected by the Evaluation Group or who may have volunteered to participate in the survey (approximately 100 questionnaires to be distributed). Up to 50 individuals drawn from a cross-section of the organizations/individuals that were surveyed will be selected and, if possible, interviewed (20 minutes per interview).
Progress Reports	Review reports generated for or by CPSI with relation to the implementation of specific initiatives.
Fin. Reports, Audits	Review reports generated for or by CPSI with respect to specific initiatives and their related costs.
Committee Reports	Review of committee reports and interviews with committee members to determine progress of committee and related work streams.
Other	Review, as needed, of other documents including CPSI compilations examining support provided to institutions, reports published by Health Canada, IHI and other relating to national and international efforts to improve patient safety.

Evaluation Implementation

An integral component of the evaluation framework for CPSI is the timetable for the interim and final evaluation studies. This section sets out the proposed schedule for conducting these studies for CPSI.

Evaluation Timetable

Health Canada requires that the initial program evaluation be completed by February 6, 2007. To meet this deadline, preliminary plans will be drafted by May 2006 for Board approval in June 2006. As CPSI would like to present the mid-way evaluation at the October 2006 annual meeting of the Voting Members of CPSI, the evaluation must be completed by mid-September for final Board approval.

This program evaluation will be managed and conducted by a Working Group. The Working Group will report to the chair of the Board and CEO of CPSI, who will provide oversight on this project, assisted by staff.

Evaluation Working Group Composition

The Evaluation Working Group will be chaired by Dr. Michel Brazeau. Mrs. Sharon Sholzberg-Gray, CEO and President, Canadian Healthcare Association, who helped to develop the CPSI Act of Incorporation and Bylaws, will serve as vice-chair.

The participation of a practising physician, a nurse and a pharmacist would be secured. An invitation to suggest names would be extended to relevant national organizations. These organizations would be encouraged to consider and recommend highly respected individuals with experience and expertise in patient safety and, when possible, the added benefit of knowledge and skills in program evaluation.

Others might be involved if the funding is available. They would be selected as above and could include someone from the field of the social sciences and humanities, an expert in patient safety whose primary activity occurs outside Canada, and a government representative. However, one may argue that governments will already be very intimately involved in the process because their representatives on the CPSI Board of Directors will be participating in the evaluation process and individually contacted.

An expert in survey and interview methodology may be required to help the group with design issues relative to the survey and structured interviews.

The assistance of CPSI staff would be appreciated for document preparation and distribution, scheduling of interviews, the logistics of group meetings including preparation, travel arrangements and note taking, and the provision of general secretarial access. Should this be impossible, CPSI will budget and secure other resources for this purpose.

Appendix 2: Summary of the CPSI Strategic Business Plan

1.0 Vision, Mission, Priorities, Measures of Success

We envision a Canadian health system where patients, providers, governments and others work together to build and advance a safer health system; where providers take pride in their ability to deliver the safest and highest quality of care possible; and where every Canadian in need of healthcare can be confident that the care they receive is the safest in the world.

1.1 CPSI Mission

In working towards this broad vision for Canada's health system, the CPSI mission is to provide national leadership in building and advancing a safer Canadian health system.

1.2 CPSI Overarching Themes

The work of CPSI is built around the following three overarching themes:

1. Define patient safety issues in Canadian healthcare

Patient safety spans the continuum of care, care settings, and patient populations. The complex and dynamic set of issues that contribute to patient safety demand continuous work to both understand and maintain focus on the problem. We will work with health system stakeholders to understand and identify issues of priority importance for patient safety in Canada, leading to a coordinated patient safety research and improvement agenda.

2. Identify leading practices and effective interventions

Practices that lead to improved patient safety are being developed and implemented across the country – yet, adverse events are still repeated. We will support research that seeks to understand adverse events, their causes and potential solutions. We will connect with providers, governments, industry and the public to gather information regarding “what is working”. Finally, we will disseminate this information across a range of clinical, educational, and organizational settings – bringing forward practical information and strategies to support improvements in patient safety.

3. Champion necessary change through partnerships, stakeholder engagement and transparent communication

Improvements to patient safety happen because of changes made by providers at the frontline of the health system. Accordingly, we see ourselves as an instrument to support change. We will provide leadership by working with partners to create opportunities for providers, researchers and governments to develop and implement innovations. We will work to remove barriers – technical, legal, cultural and organizational – that presently inhibit improvements to the Canadian health system. We will facilitate the development of systems that measure the impact of changes. Finally, we will

support broad dissemination of information about optimal patient safety practices and lessons learned.

1.3 Key Priorities by Theme

Theme 1: Define patient safety issues in Canadian healthcare

1.1 Target priority issues for CPSI to concentrate on over the next 3-5 years.

1.1 (a) Identify priority issues for the work of CPSI through extensive networking and consultation at the regional and national levels, with governments, practitioners, researchers, the public and other health system stakeholders.

1.1 (b) Host an annual national conference to discuss major patient safety issues facing the Canadian health system and progress made in addressing those issues.

1.2 Work with federal, provincial and territorial Departments of Health and other relevant agencies to create a national reporting system and a storehouse of patient safety information.

1.2 (a) Undertake an environmental scan of systems currently deployed in Canada for monitoring adverse events, errors and critical incidents.

1.2 (b) Collaborate with CIHI, CCHSA, provincial/territorial governments and other health system stakeholders to identify nationwide indicators of patient safety.

1.2 (c) Support the development and adoption of a critical incident registration database.

1.2 (d) Report annually regarding progress on targeted patient safety issues.

Theme 2: Identify leading practices and effective interventions

2.1 Collaborate with partners to develop and support a research agenda around patient safety in Canada's health system.

2.1 (a) Work with leaders of granting councils, and national and international experts to identify ways to increase the scale of research

(including applied and policy relevant research studies) and develop a research agenda.

2.1 (b) Advance the patient safety research agenda by developing a peer-reviewed CPSI grant program and encouraging Canadian Institutes of Health Research, Canadian Health Services Research Foundation and other granting councils to adopt patient safety as a crosscutting theme or designated area for research competitions.

2.2 Develop models and mechanisms for bringing together groups of professionals to solve specific problems.

2.2 (a) Promote access to tools through the CPSI website, including models for root cause analyses and case studies that describe the application of leading practices in specific situations.

2.2 (b) Work with partners to fund and organize learning opportunities among peers (i.e. collaboratives) and with experts (i.e. chat room on the website, phone-in panels, annual safety conference, etc.) related to targeted patient safety issues.

2.3 Disseminate leading practices to targeted stakeholders.

2.3 (a) Develop a comprehensive inventory of leading practices in patient safety and ensure that it is widely accessible through the CPSI website.

2.4 (b) Develop a Canadian patient safety publication with broad stakeholder representation on the editorial board.

2.4 Develop a standardized and validated patient safety curriculum for all disciplines involved in patient care, healthcare administration and health policy development.

2.4 (a) Recruit multi-disciplinary “safety champions” with a mandate to develop national educational standards; create a core curriculum applicable across areas of expertise; and identify tools and data needed to support the curriculum within specific educational settings.

2.4 (b) Work with others to fund the development of a national curriculum, including curriculum guidelines for undergraduate education in all health professions, and gain the support of national certifying bodies and other professional associations and licensing authorities.

2.4 (c) Establish and support operation of a leadership development program to produce a cadre of patient safety leaders from a wide

range of disciplines. Specific offerings may include national courses and fellowships in patient safety.

2.4 (d) Work with partners to fund the development and adoption of programs that provide health professionals with state of the art simulation-based training in a multi-disciplinary environment.

Theme 3: Champion necessary change through partnerships, stakeholder engagement, and transparent communication

3.1 Develop an infrastructure for innovation and to support advancement and delivery of programs and technologies intended to improve the safety of Canada's health system.

3.1 (a) Work with partners to fund and organize innovative programs and technologies related to targeted patient safety issues, including pan-Canadian learning collaboratives and multi-disciplinary simulation exercises focused on priority areas.

3.1 (b) Support the development of the Canadian Medication Incident Reporting and Prevention System.

3.2 Develop a legislative model for sharing of information (i.e. protection from being subpoenaed if information is shared), no-fault insurance and mandatory reporting of adverse events. This model will be intended for examination on a provincial basis.

3.2 (a) Develop and promote implementation of a legislative model on privacy and confidentiality of personal information that balances the need to collect and share information with the need to protect the privacy and confidentiality of individuals and information gathered during patient safety reviews.

3.2 (b) Support the development and implementation of uniform standards and processes for data collection that will permit information to be de-identified where possible, while ensuring the accuracy and integrity of the information.

3.2 (c) Examine the tort system and its effects on patient safety, and work with provincial/territorial governments and other stakeholders to make appropriate changes.

3.3 Increase public awareness regarding the appropriateness of patient safety as a systems issue and the need to report adverse events and "near misses".

3.3 (a) Develop communication material for the public outlining personal measures that can be taken as it relates to patient safety.

3.3 (b) Engage and work with the media regarding their role in supporting a "culture of safety".

3.4 Encourage and advise regarding models for reporting policies, disclosure policies, and procedures to analyze near misses.

3.4 (a) Develop and promote the adoption of national policy guidelines regarding the disclosure of adverse events and for communication between health professionals and patients/families when errors occur.

1.4 Success Measurement Framework

The table below summarizes the framework used by the CPSI to measure its success in its Business Plan.

Perspective	Short-term Measure	Target (2005/2006)
Customer Focus	Member Satisfaction	Survey results indicate 90% satisfaction among Voting Members with performance of CPSI through 2005/2006
	Stakeholder satisfaction with material produced	Survey results indicate 90% satisfaction among "users" of CPSI materials
Value Creation	Financial leverage ratio	Four dollars directed towards patient safety in Canada by partners for every dollar spent by CPSI
Enablers of Improvement	Development of key enablers of change to Canada's healthcare system	Key elements of the infrastructure enablers of change to necessary to enable improvements to Canada's health system will be established or enhanced, including: <ul style="list-style-type: none"> ▪ A patient safety research agenda and associated disbursement of funds [2.1(a)]; ▪ Learning collaboratives focused on specific patient safety issues [2.2(b)]; ▪ A legislative model for sharing of information, no-fault insurance and mandatory reporting of adverse events [3.2]; ▪ Undergraduate curriculum guidelines for patient safety [2.4(b)]; and ▪ A patient safety leadership development program, including fellowships [2.4(c)].
Internal Processes	Establishment of communications network and infrastructure	A network of partnerships and relationships will be established with Canadian and international health system stakeholders. Mechanisms to foster these relationships will be developed, including: <ul style="list-style-type: none"> ▪ Membership and Advisory Committees; ▪ A website, including tools and case studies [2.2(a)]; ▪ An annual conference [1.1(b)]; ▪ An annual report [1.2(d)]; and ▪ A Canadian patient safety publication [2.4(b)].

Appendix 3: Specific Responses to On-line Survey re: Accomplishments

#1 Accomplishments

Safer Healthcare Now!

1. CPSI has spearheaded the Safer Healthcare Now Campaign and has been supporting it nationally. The importance of this initiative will be to provide solid data to show that where patient safety processes are applied, real and measured improvements can be made.
2. Safer Healthcare Now
3. The Patient Safety Now campaign
4. Patient Safety Campaign - promoting pan-Canadian approach to patient safety
5. Leadership to the Safer Healthcare Now initiative across Canada
6. Launch of Safer Healthcare Now campaign
7. The Safer Healthcare Now initiative and the six strategies that this initiative promotes are the most important advances. Particularly the Medical Emergency Team concept, which has had widespread acceptance across the country.
8. Safe Health Care Now Campaign
9. Safer Health Care Now program very real ,visible, and useful to institutions and providers
- 10.Safer Healthcare Now Campaign
- 11.Safer Healthcare Now
- 12.Safer Health Care Now
- 13.Leadership on Safer Healthcare Now
- 14.Safer Healthcare Now initiatives
- 15.Campagne "Des soins de santé plus sécuritaires - maintenant!"
- 16.SHCN
- 17.Safer Healthcare Now! campaign (more awareness, education)

Specific Protocols and Recommendations

1. Surgical site infection protocols -- antibiotic administration, normothermia, shaving, etc... have been very successful!
2. Sentinel Events: via CCHSA we have learned about sentinel events, instituted education and training related to investigation, reporting, and follow up of such events
3. Look-Alike-Sound-Alike (LASA) notifications
4. Removal of KCL vials from nursing units
5. Having enough staff to carry out the appropriate care to patients-holistically
6. Fall prevention
7. WHO Global patient safety Challenge
8. Review of overall policy on patient safety
9. Hand Hygiene or infection control
10. On our LTC setting we are using hip protectors for our mobile seniors to prevent hip fractures
11. Incorporating resident safety in our strategic plan

Other Efforts to Raise Awareness

1. None except some publicity (i.e. regards to the institute)
2. Heightened awareness of the importance of the systems connection to patient safety incidents
3. Heightened interdisciplinary (professional) awareness of the existence of unintentional harm to people in health care settings
4. Awareness of safety issues through a strong collaboration of healthcare associations and agencies
5. Canadian Patient Safety Week
6. Canadian patient safety week
7. Raising awareness about patient safety amongst governments and other key stakeholders

Research

1. Currently conducting a survey of nursing baccalaureate programs to identify what is being taught to student nurses regarding patient safety.
2. Les projets de recherche
3. Culture of Safety Survey

4. Establishing a grants competition for pt safety research and demonstration projects
5. Creating a culture of Safety

Networking and Partnership Development

1. From the list provided it would appear that CPSI is making lots of contacts and has started and picked up on initiatives going on elsewhere. It is too early to know whether any of these initiatives could be called accomplishments
2. Effet rassembleur de tous ceux qui s'intéressent à la sécurité des soins
3. Has begun to develop partnerships with a variety of organizations.

Root Cause Analysis Framework

1. Root Cause analysis framework and training available
2. Root Cause Analysis Framework

Other Comments

- No specific ones. All goals identified for CCHSA focused on important...
- Government initiatives related to ceiling lofts - Do not know if CPSI has a role...awareness of patient safety requirement through CCHSA? involvement CPSI

#2 Accomplishments

Specific Protocols and Recommendations

1. The hand hygiene initiative
2. Development of Guidelines for Disclosure of adverse events
3. Revised procedure re double checking of PCA pumps
4. The leadership role of the supervisor working with unregulated staff
5. Least restraints
6. Leadership Walkarounds
7. Reporting of incident report
8. Understanding critical incidents and disclosure
9. Rapid Response Team being initiated
10. Ceiling track lifts which reduce injuries to seniors and staff in physio or rehab programs in our facility to keep seniors as active as possible
11. CCHSA's Required Organizational Practices - assuming that CCHSA ROP's are derived from work done by CPSI, this information has been

helpful in guiding development of education and training programs within our organization.

Research

1. While the results are not yet in, CPSI made available significant funds for research related to various aspects of patient safety. Much of this research may not have been possible without this CPSI initiative.
2. Research grants program
3. Research grants for those interested in patient safety and allowing for demonstration projects to be funded.
4. Research Grants
5. CPSI Research Grant Competition
6. Research projects to highlight safety issues
7. Fonds disponibles pour débiter certaines initiatives notamment en recherche clinique
8. Funding research
9. Research
10. Bourses de recherche sur la sécurité des patients

Building Awareness and Sharing Information

1. Implementation of the Canadian Patient Safety Week with a focus this year on hand washing with the World Health Organization
2. Safer Healthcare Now program
3. Special journal on patient safety
4. Providing accessible information via the excellent web site
5. La campagne "Des sains sécuritaire maintenant".
6. Canadian Patient Safety Week
7. Advancing the understanding of pt safety issues and challenges associated with home, LT and community care.
8. CPSI internet site as a resource for patient safety leaders, staff (tools and resources available)

Networking and Partnership Development

1. Developing Halifax 6
2. Events that bring together and motivate those engaged in patient safety work (e.g. Halifax conference series, executive patient safety series)

3. Support for regional educational meetings
4. Bringing together leaders from various disciplines and aspects of patient safety to begin discussions and work collaboratively on complex issues such as legal/regulatory, core competencies and so on
5. Collaboratives in western Canada

Other

- CPSI is very young and not well known across the country except as a new entity. It will have growing pains for a while
- Develop a policy on disclosure of adverse events
- Safety is every professional's responsibility
- Executive patient safety series

#3 Accomplishments

Awareness, Education and Sharing of Information

1. Publication and promotion of best practices through publications and conferences
2. Canadian patient safety week - hand hygiene focus
3. Increasing media coverage of patient safety
4. Its support for the Safer Healthcare NOW program is laudable
5. Bel effort de coordination pour la semaine canadienne de la sécurité des patients
6. Coordinating the Halifax symposia
7. La prise en charge d'Halifax
8. Safer Healthcare Now!
9. Patient Safety Week
10. Canadian Patient Safety Week initiatives
11. Semaine canadienne de la sécurité des patients
12. Education regarding pt safety in community settings
13. Canadian Adverse Event Reporting - I would have put this #1 as I think it is probably the most important, but not yet developed enough
14. Education for staff, families, residents and volunteers about resident safety

Research

1. Ongoing research
2. Funding for research projects in the area of patient safety

3. Funding research
4. The support for research into patient safety
5. Research and publications on patient safety
6. Education and innovation in training

Specific Protocols and Guidelines

1. National Guidelines on disclosure under development
2. Guidelines for disclosure of adverse events
3. Hand washing: again assuming work done by CPSI has guided Regional Authorities; the information from our Region has provided guidance in developing procedures, training, and education on this basic infection control practice.
4. Development of national guidelines for disclosure of adverse events
5. Revised MI pathway to include smoking cessation education
6. Disclosure and Critical Incident Review policies

Other

1. Formation of CPSI
2. Establishment of Advisory Committees
3. Encouraging, motivating, "pushing" administrators to respect the impact staff support can have to fostering a NO shame, No blame environment within healthcare facilities
4. Improvements are possible when anticipatory and proactive action is taken
5. An overarching pan Canadian consistent credible 'presence' to build/maintain the momentum of working to improve patient safety in Canada
6. Knowing the importance of listening and communicating
7. Review of stats on a regular basis to make necessary changes
8. La publication d'un nombre important d'autres nombre important d'article.
9. Starting to look at Root cause analysis
10. CPSI is beginning to bring together the many diverse individuals and organizations with an involvement or interest in patient safety. This has and will continue to improve our efforts both by encouraging people to work together, and by avoiding unnecessary duplication.