

**Evaluation of the  
National Patient Safety Consortium &  
Integrated Patient Safety Action Plan**

**FINAL REPORT**

**JULY 2018**

**Vision  Results**

## Vision & Results

Vision & Results Inc. was established in 2004 and is a federally incorporated health and social services management consulting firm located in Ontario, Canada. Our organization transformation specialists focus on: innovation, strategy, operations and evaluation. We empower individuals, teams, organizations, and systems to achieve their full potential through rapid cycle, participatory action-based learning and improvement. For more information, visit: [www.visionandresults.com](http://www.visionandresults.com).

# TABLE OF CONTENTS

**TABLE OF CONTENTS**..... **1**

..... **2**

Background ..... 2

Evaluation Approach & Methodology ..... 4

Findings ..... 7

Lessons Learned ..... 9

Recommendations ..... 9

Implementation Plan ..... 11

Conclusion..... 11

## Executive Summary

### Background

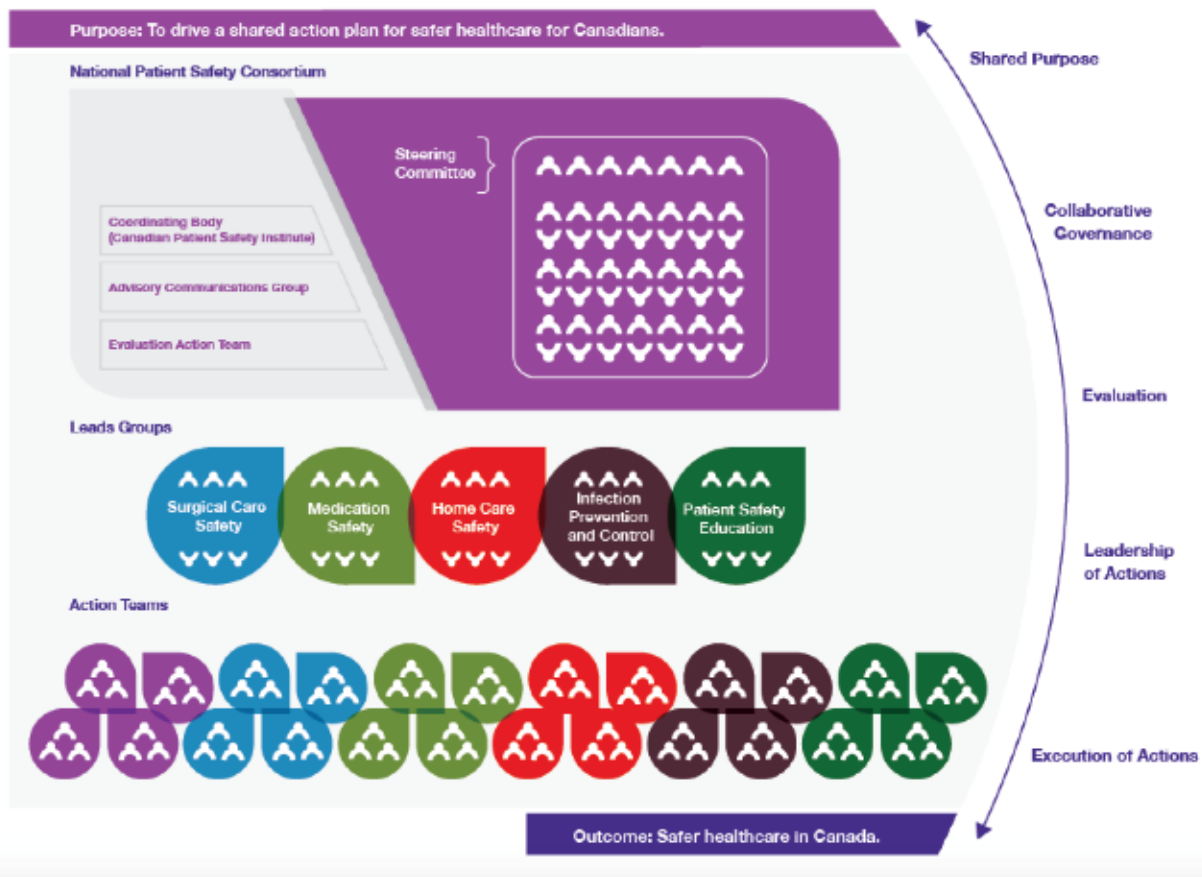
There is tremendous activity around patient safety in Canada. There are quality and patient safety councils in most provinces and many national organizations dedicate all or part of their mandate to patient safety. It is widely accepted that patient safety is one dimension of a broader quality framework for healthcare. Information is gathered, research pursued, innovations introduced, and money spent. The question inevitably follows: are Canadian patients getting the full benefit of all that energy? So many of us collectively devote resources to making healthcare safer for patients — are they being used to the best advantage? To that end, the Canadian Patient Safety Institute (CPSI) initiated efforts to partner with key organizations to accelerate the pace, spread, and scale of patient safety improvement.

On January 27, 2014, healthcare leaders from across Canada met in Toronto to shift patient safety into higher gear to help transform our current system. They gathered at the invitation of the Canadian Patient Safety Institute (CPSI), which made a commitment to work with partners to accelerate patient safety in its 2013-2018 business plan. It was essential, in CPSI's view, to start with creating a consortium, because any effort to drive real change in safety would have to be much bigger than one organization could manage and could not succeed if it were seen to be solely one organization's agenda. Emerging from the January 2014 meeting was the foundation of a National Patient Safety Consortium with a clear action plan to advance patient safety across the country.

A National Patient Safety Consortium (Consortium), comprised of organizations, patients and family members from across Canada was formed to drive a shared action plan for safer healthcare for Canadians – the Integrated Patient Safety Action Plan (Action Plan). The Consortium Steering Committee governed the collaboration and measurement and evaluation activities was led by the Evaluation Action Team. The Integrated Patient Safety Action Plan included activities in five priority areas:

1. Medication Safety
2. Home Care Safety
3. Infection Prevention and Control
4. Surgical Care Safety
5. Patient Safety Education

Leads Groups identified the actions for the priority areas which were completed by the Action Teams. The Canadian Patient Safety Institute served as the Coordinating Body of this initiative. The intended outcome of the Consortium and Action Plan was *“safer healthcare in Canada”*.



The work and evaluation of the five-year National Patient Safety Consortium was grounded in the “Collective Impact Model” shown in the figure below<sup>12</sup>. The model consists of three phases:

1. “Early Years” (collaborative design and implementation)
2. “Middle Years” (behaviour and system change)

<sup>1</sup> Kania, J., and Kramer, M. Collective Impact. 2011. Stanford Social Innovation Review 9(1):36–41.

<sup>2</sup> Preskill, H., Parkhurst, M., Splansky Juster, J. 2014. Guide to Evaluating Collective Impact. FSG Consulting.

### 3. “Late Years” (goal achievement/impact)

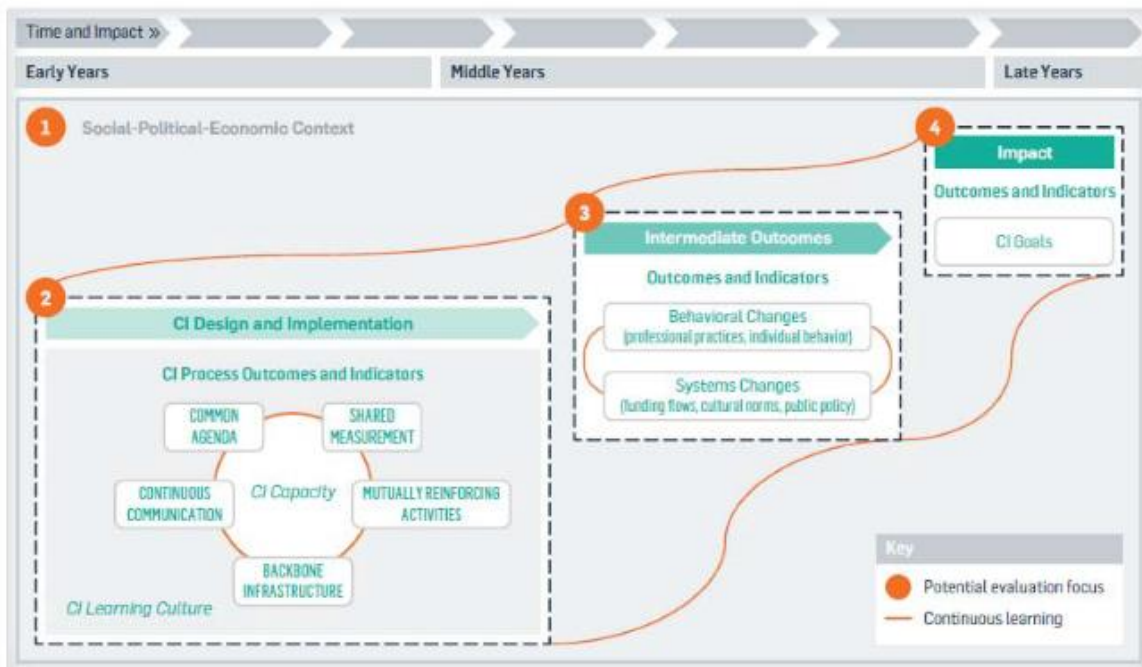


Figure excerpted from *Guide to Evaluating Collective Impact: learning and evaluation in the collective impact context, Part 1. Page 12.*

Five conditions conducive to achieving Collective Impact are:

1. Common agenda amongst collaborating participants
2. Continuous communication between participants
3. Backbone infrastructure coordinating participants
4. Mutually reinforcing activities
5. Shared measurement system

From the diagram above, the Social-Political-Economic Context refers to the broader health system landscape in which the Collective Impact initiative was taking place. Factors such as patient demographics and experience, government policy and regulation, and the economic environment shape the collaborative structure, processes, momentum and degree of impact achieved.

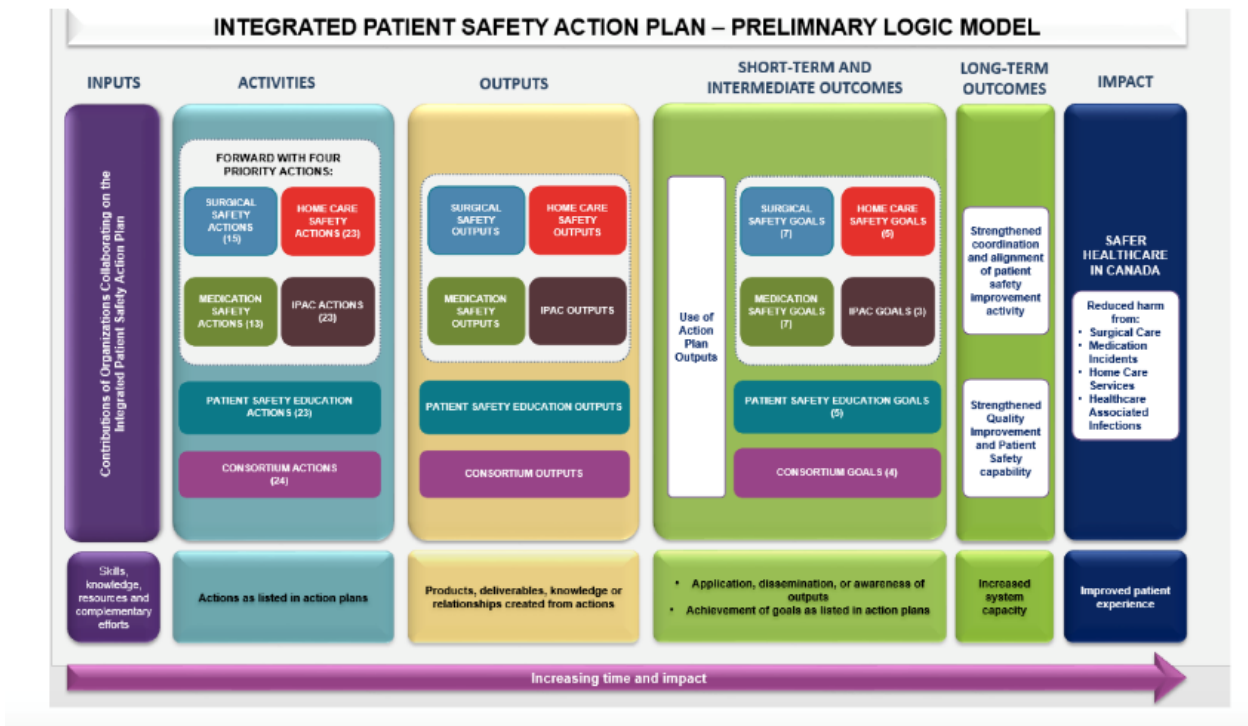
The evaluation involved examining the extent to which each of the Collective Impact phases and associated activities contributed to patient safety improvement, and identification of the barriers and enablers in the environment that may have affected the progress made.

## Evaluation Approach & Methodology

In February 2017, Vision & Results Inc., a health and social services management consulting firm, was selected through a Request for Proposal process to complete an independent evaluation of the National Patient Safety Consortium and Integrated Patient Safety Action Plan.

The logic model<sup>3</sup> below, developed by the Evaluation Action Team<sup>4</sup>, guided this evaluation. The logic model articulated the relationships between the inputs, activities, outputs and outcomes of the collaborative work.

This evaluation assessed progress against the specified short, medium and long-term outcomes of the



Integrated Patient Safety Action Plan, with the recognition that the initiative had been underway for four years since the establishment of the Consortium.

<sup>3</sup> Evaluation Framework for National Patient Safety Consortium and Integrated Patient Safety Action Plan, August 2016, p. 6.

<sup>4</sup> Academy of Canadian Executive Nurses, Alberta Health, Atlantic Health Quality and Patient Safety Collaborative, Association of Faculties of Pharmacy of Canada, Canada Health Infoway, Canadian Association for Drug and Technologies in Health, Canadian Association of Paediatric Health Centres, Canadian Medical Protective Association, Canadian Nurses Association, Canadian Patient Safety Institute, Canadian Pharmacists Association, Health Canada, Health Quality Ontario, Health Quality Council of Alberta, Institute for Safe Medication Practices Canada, Mental Health Commission of Canada, New Brunswick Health Council, Patients for Patient Safety Canada.

The Evaluation Action Team developed an Evaluation Plan that included four key evaluation questions, sample measures or /indicators and data sources. Evaluation findings and recommendations address each of these questions.

**National Patient Safety Consortium & Integrated Patient Safety Action Plan  
Evaluation Questions**

- 1. How do we collaborate?**
  - Consortium’s capacity and approach for effective collaboration.
  - Collective Impact approach used to guide the interaction and collaboration of participating organizations, and how these activities enabled the actions set forth in the Action Plan.
- 2. What has been done?**
  - Execution of the actions in the Action Plan.
- 3. How well is it working?**
  - Achievement of the goals stated in the Action Plan, the extent to which outputs were used and leveraged by players in the healthcare community, and whether there was an increase in system capacity to coordinate and improve patient safety.
- 4. Is it making a difference?**
  - Impact that the Consortium had on system capacity to coordinate, improve and understand patient safety as well as the overall impact of the Action Plan on patient safety outcomes.

The evaluation was completed in 2 phases:

1. Interim findings and recommendations to the Consortium and Steering Committee by October 2017.
2. Final findings and recommendations to the Consortium and Steering Committee by April 2018.

Evaluation activities during both phases included reviewing documents and data, and conducting interviews and focus groups with Integrated Patient Safety Action Plan participants. An extensive online survey was administered to Integrated Patient Safety Action Plan participants (which included the Consortium, Steering Committee, Leads Groups, and Action Team) during Phase 1. Analyses of the qualitative data within and across priority areas and stakeholder groups was completed. Qualitative and quantitative data were triangulated. Before the preparation of the interim and final evaluation reports, the findings and recommendations were reviewed with the Evaluation Action Team, Consortium Steering Committee, and Leads Groups.



## Findings

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### *How do we collaborate?*

- The National Patient Safety Consortium is an exemplar of Collective Impact. It solidified patient safety improvement as a national priority and created an unprecedented level of shared understanding and alignment of its long-term goal “safer health care in Canada”, and the approaches required to improve patient safety. It leveraged the expertise and experience of stakeholders, including patients and family members, to advance patient safety. It established a solid foundation and generated considerable momentum to support the spread and scale of patient safety improvements across Canada.
- The National Patient Safety Consortium was effective for the “Early Years” of the Collective Impact initiative. Its work strengthened existing partnerships and forged new ones, resulting in the development of a national patient safety agenda.

### *Recommendations*

- The structure of the National Patient Safety Consortium should now be evolved to one that designates and deepens the governance and operational roles of different partners given their mandates, strategies, and resources. Ongoing, self-sustaining mechanisms for continuous knowledge transfer and exchange of patient safety priorities and improvements, both within and across the provinces and territories, should be fostered to enable future collaborative work. The Canadian Patient Safety Institute (CPSI)’s specific role and responsibilities with respect to future collaborative work arising from the Integrated Patient Safety Action Plan should be clearly communicated to National Patient Safety Consortium participants.

### *What have we done?*

- The Integrated Patient Safety Action Plan was developed using a highly collaborative process involving numerous participants from across Canada. The resulting plan included close to 100 actions, most of which were completed. Over 33 outputs were developed including environmental scans, literature reviews, and resources and tools.
- The collaborative action plan development process engendered national buy-in and commitment to the activities. However, the Integrated Patient Safety Action Plan was a culmination of several plans, requiring complex project management and reporting. Some evaluation participants questioned the amount of time spent on reporting progress against these plans and suggested that there should have been a greater emphasis on identifying and communicating outcomes for patients and providers.
- While most of the Integration Patient Safety Action Plan items were completed, some of the actions related to output dissemination and impact measurement were removed given the time that was remaining to complete the plan. Nonetheless, Action Plan participants recognized that these outstanding actions need to be completed to improve patient safety. Many remain committed to continuing the work.

### *Recommendations*

- Now that the work of the National Patient Safety Consortium has officially ended, realizing improvement in patient safety will require decisions about future priority area activities, which outputs will be actively disseminated and implemented, and how work on developing a national patient safety measurement and monitoring system will proceed.

### ***How well is it working?***

- Most of the Integrated Patient Safety Action Plan goals were completed (86%). The goals focused on the development of guidelines, resources and tools that: advance knowledge and understanding of patient safety issues; support behaviour change; and promote a culture of patient safety. Other goals included developing indicators and identifying data required for measuring patient safety and partnering with patients and family members to improve patient safety.
- Key enablers to the progress achieved by this Collective Impact initiative included: CPSI's heightened and effective coordination and support role; extensive involvement of stakeholders; a shared vision for improved patient safety; and a concrete action plan. The effectiveness of CPSI as a coordinating body was mentioned by many as was the extensive nature of patient involvement during all stages of the development of the action plan.
- Key barriers to progress included: a lack of dedicated financial and administrative resources; competing priorities and/or time; and a need for additional implementation partners.
- Although several resources and tools were developed, active dissemination and usage of these outputs was limited.

#### *Recommendations*

- Given that the responsibility for health care delivery in Canada rests with provinces and territories, greater involvement of regional and local partners is required to effect patient safety improvement. CPSI should continue to facilitate collaborative work to ensure the national alignment of patient safety improvement priorities. CPSI should lead the development of a new and focused set of patient safety goals and strategies. Its continued leadership will ensure the relevance of future actions, and maintain the momentum that has been generated and accelerated patient safety improvement.

### ***Is it making a difference?***

- The National Patient Safety Consortium and work on the Integrated Patient Safety Action Plan built significant capacity across Canada to coordinate, improve and understand patient safety priorities. While the involvement of patients and family members in health care improvement activities has risen in recent years, this Collective Impact initiative increased the depth of their involvement. Patients were equal partners and decision-makers in all activities including planning, implementation and evaluation of the Consortium and action plan, which fundamentally grounded the initiative in the experiences of people who use the health care system. A common patient safety language emerged among Integrated Patient Safety Action Plan participants across the country, which facilitated deeper conversations and sparked additional patient safety improvement initiatives beyond the scope of the action plan.

#### *Recommendations*

- Making a difference for patients and family members, as measured by reductions in harm and improved patient experience requires taking the outputs of the Integrated Patient Safety Action Plan to frontline healthcare providers for implementation. At the same time, there are critical roles for policy, standards and regulatory organizations to elevate expectations for safe care across the entire health system.
- Consortium participants are willing to continue collaborating on patient safety improvement work provided that the goals and expectations for their involvement are clear, future activities are aligned with their organizations' strategic priorities, and that there is a focus on measuring and achieving tangible impacts. Significant momentum for realizing patient safety outcomes has been generated by

the National Patient Safety Consortium and should be sustained. A national measurement and monitoring strategy, including clearly defined indicators, baselines and targets, information systems, and reporting processes are essential for evaluating whether impact has been made at the project, organization and system-levels.

## Lessons Learned

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- Partners recognized CPSI’s significant, above the norm, role in facilitating a Collective Impact initiative of this magnitude. CPSI has embraced this leadership role by continuing to build patient safety improvement capacity among health system partners so that they may in turn effectively assume their respective patient safety improvement leadership roles in a coordinated manner.
- A sustained long-term focus on building patient safety improvement capacity in all sectors and at all levels of the health system is essential for reducing harm and improving patient safety.
- Patients and family members played an essential role in improving patient safety; more patients and their families should be empowered with the resources and tools to effect change.
- Defining, measuring and reporting on short, medium and long-term patient safety outcomes will help to both sustain and generate additional momentum. These activities should be a part of any large-scale, long-term Collective Impact initiative.
- Moving from a focus on patient safety as an “initiative” or a “project” completed by a few to an area of responsibility shared by all is the system cultural shift that CPSI and its partners will need to strive to achieve going forward.
- The Collective Impact model and collaborative governance model was successfully applied to this large-scale change work.

## Recommendations

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### ***Commitment, Capacity-Building & Focus***

1. CPSI and its partners should evolve the National Patient Safety Consortium to a governance structure that includes a focused set of partners committed to continuing collaborative work to advance strategic priorities for patient safety across Canada. Each partner should have a clearly specified leadership role and a set of expectations and commitments pertaining to key patient safety improvement functions including in policy, strategy, implementation, evaluation and measurement.
2. CPSI should create sustainable mechanisms (e.g., Annual Patient Safety Congress, Communities of Practice, etc.) to facilitate ongoing communication, knowledge transfer and exchange, as well as support future collaborative efforts to build additional health system capacity for patient safety improvement.
3. CPSI should clarify to partners, its role as leader, collaborator, and enabler, and how it will invest its resources to make the greatest impact on patient safety improvement given its mandate, resources and strategic directions.

### ***Demonstrating Progress & Building Additional Capacity***

4. Consortium participants should celebrate the successful completion of the Integrated Patient Safety Action Plan. This should include ensuring that participants acknowledge each other for their significant contributions of time, resources, and expertise as the official timeframe for the plan comes to an end.
5. CPSI and its partners should select outputs and/or ongoing actions from the Integrated Patient Safety Action Plan and be explicit about future activities in each priority area. Efforts should be made to ensure that Consortium members are clear about plans, as well as the roles and responsibilities of various partners going forward.
6. CPSI and its partners should determine and communicate their specific roles and responsibilities regarding the measurement of progress and impact for priority initiatives, and encourage other stakeholders in the health system to consider measurement and monitoring in areas aligned with their respective mandates.

### ***Sustaining, Spreading and Scaling Efforts***

7. CPSI and its partners should develop specific strategies to spread, implement and scale key outputs, addressing key enablers for implementation and adoption including leadership, funding, implementation vehicles, reporting, and measurement.
8. CPSI should continue to support the identification of and brokering with provincial, territorial, regional and local implementation partners to utilize their jurisdiction-specific mechanisms and processes to encourage the adoption of outputs, and assess their impact on improving patient safety and reducing harm.
9. CPSI and its partners should continue to work with Health Canada, provinces and territories to develop strategies to deepen the shared commitment to a national agenda and to align and focus future goals and strategies for patient safety.

### ***Realizing Impact***

10. CPSI and its partners should sustain the momentum created by the National Patient Safety Consortium and the work completed on the Integrated Patient Safety Action Plan to realize improvements to patient safety by:
  - Communicating broadly across Canada and other jurisdictions the difference achieved in building a national common vision, completing concrete actions, and developing a shared commitment to improving patient safety.
  - Continuing with CPSI's "unrelenting focus" on the patient safety agenda at the system/national level, facilitating leading practice knowledge transfer and exchange among provinces and territories, and working with partners to embed patient safety priorities into their strategies, goals and objectives.
  - Demonstrating the impact of a focused set of patient safety improvement projects as part of a renewed national patient safety action plan, and supporting the spread and scale of successful evidence-based patient safety improvements.
11. CPSI and its partners should develop a national patient safety measurement strategy including: a robust and common set of indicators at the project, organization and system-levels that provincial and territorial jurisdictions and their health care providers can adopt to measure impact and provide evidence to inform policy, standards and regulation development, as well as other future investments in patient safety.

## Implementation Plan

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In the short-term (0-6 months) the activities recommended for CPSI and its partners are to:

- Celebrate the accomplishments of the Integrated Patient Safety Action Plan participants.
- Select areas from the Integrated Patient Safety Action Plan for ongoing work. Develop strategies to implement, spread and scale outputs.
- Evolve the current governance structure and clarify CPSI's role, as well as partner roles and commitments.
- Continue to develop a national patient safety measurement and monitoring system.

For the medium-term (1-2 years), the recommended activities are to:

- Continue to work with partners to implement and measure impact of improvements.
- Create sustainability mechanisms for ongoing knowledge transfer and exchange.
- Establish measurement roles and responsibilities.
- Sustain momentum through a focus on patient safety, completing additional concrete actions, and measuring and monitoring patient safety improvement efforts.

Over the long-term (3 years+), it is recommended that CPSI and its partners:

- Continue to work with Health Canada and the provinces and territories to align and commit to a focused national patient safety agenda with measurable goals and activities.

## Conclusion

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Currently, substantial harm occurs daily within the Canadian health care system. The work of CPSI, National Patient Safety Consortium, and Integrated Patient Safety Action Plan participants has shown that progress in building patient safety capacity across Canada can be aligned and accelerated using a Collective Impact approach. Sustained momentum is required to prevent and reduce patient safety incidents and achieve safer health care for Canadians.

Dissemination, implementation, spread and scale of key outputs arising from the completed Integrated Patient Safety Action Plan can contribute to improved patient safety. The implementation of CPSI's new strategic plan, along with ongoing collaboration and support from funders, patients and families and additional health care partners across the provinces and territories in establishing and completing the next national patient safety plan holds promise for improved patient safety.