




## Patient Safety and Quality Priorities for Consortium Participants



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## Purpose

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The purpose of this environmental scan is to provide a high level summary of the patient safety and quality priorities and goals for participants of the National Patient Safety Consortium. More specifically, the goals of this document are to:

- 1) Confirm that all partners have a part to play in advancing patient safety
- 2) Confirm that we now have a call to action for patient safety (as demonstrated in Forward with Patient Safety: Commitment through action paper<sup>1</sup>)
- 3) Demonstrate alignment with current work and priorities of Consortium members

The websites of Consortium participants were searched for strategic plans and key corporate documents; patient safety and quality legislation was also reviewed; as well as public reporting of patient safety and quality indicators. Some recently published literature on quality and patient safety is also described. The scan was also shared with Consortium participants for their review and input.

This scan is the third in a series of environmental scans that was shared with the National Patient Safety Consortium. The first scan is an international scan on patient safety and quality priorities for nine countries. The second scan explores principles for leading large scale change.

This scan is also an action directly from the Consortium Action Plan, Forward with Patient Safety: Commitment through action. The specific action is to “complete an inventory and environmental scan of current patient safety initiatives by provinces, territories and national/provincial organizations.”<sup>1</sup>

## Limitations

The organizations and activities included in this scan do not reflect all of the patient safety and quality initiatives across the country. Many activities are taking place at regional and local levels, and some activities are not posted publicly. Rather, this scan highlights some of the larger initiatives from a national, provincial, and territorial perspective of the organizations that are involved in the National Patient Safety Consortium.

This document was prepared in collaboration with the Consortium members (from November 2014 to January 2015), and was updated by the Canadian Patient Safety Institute (CPSI) in October 2015 to give a more complete picture of patient safety priorities of all participants.

## Canada

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In Canada, many organizations are involved in patient safety and quality initiatives at the federal, national, provincial, territorial, and local levels. This document presents a profile of the participants of the National Patient Safety Consortium. This includes the following organizations:

### **Federal Health Portfolio**

- Health Canada
- Canadian Institute for Health Research (CIHR)
- Public Health Agency of Canada (PHAC)

### **National**

- Accreditation Canada
- Canadian Agency for Drugs and Technology in Health (CADTH)
- Canadian College of Health Leaders (CCHL)
- Canadian Institute for Health Information (CIHI)
- Canadian Foundation for Healthcare Improvement (CFHI)
- Canada Health Infoway
- Canadian Patient Safety Institute (CPSI)
- Patients for Patient Safety Canada (PPFSC)
- Infection and Prevention Control Canada (IPAC Canada)
- Institute for Safe Medication Practices Canada (ISMP Canada)
- Mental Health Commission of Canada

### **Provincial/Territorial Organizations and Departments of Health**

- Alberta Health
- Alberta Health Services
- Atlantic Health Quality and Patient Safety Collaborative
- British Columbia Patient Safety and Quality Council
- Health PEI
- Health Quality Council of Alberta
- Health Quality Council (Saskatchewan)
- Health Quality Ontario
- Manitoba Institute for Patient Safety
- New Brunswick Health Council
- Nova Scotia Quality and Patient Safety Advisory Committee
- Ontario Hospital Association
- Ontario Ministry of Health and Long Term Care

- Government of New Brunswick
- Government of Newfoundland and Labrador
- Government of Nova Scotia
- Government of Prince Edward Island
- Government of Northwest Territories
- Government of Saskatchewan
- Government of Yukon

### **Associations/Professional Groups**

- Academy of Canadian Executive Nurses
- Association of Faculties of Pharmacy of Canada
- Canadian Association of Paediatric Health Centres
- Canadian Association of Schools of Nursing
- Canadian Medical Protective Association (CMPA)
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Home Care Association
- Canadian Pharmacists Association
- Canadian Society of Medical Laboratory Sciences
- HealthCareCAN
- Healthcare Insurance Reciprocal of Canada (HIROC)
- Patients Canada
- Royal College of Physicians and Surgeons of Canada
- The College of Family Physicians of Canada

These organizations make up the National Patient Safety Consortium and are advancing patient safety and quality initiatives at all levels of the healthcare system, as described in more detail below. The organizations are listed in alphabetical order followed by federal/provincial/territorial health portfolios.

### **Accreditation Canada**

Accreditation Canada's strategic priorities for 2014-2016 are: <sup>2</sup>

- 1) Increasing value to clients through enhanced offerings of products and tools
  - Enhance the value of the program for health services organizations through customization.
  - Align program requirements, where possible, with jurisdictional priorities, while continuing to drive system improvement.
  - Provide tools and resources to help organizations improve performance measurement and support improvement objectives.
  - Collaborate and partner with other quality, safety, and standards-setting organizations to

optimize the accreditation experience for client organizations.

- 2) Maximizing uptake of programs and services to advance quality
  - Tailor programs to meet the needs of diverse organizations (large, multi-site and small community-based) to advance quality.
  - Enhance the focus on outcomes for the program to support a more comprehensive view of performance.
- 3) Being recognized by clients and the public as a trusted source of information on quality and patient safety in health care
  - Leverage the accreditation data to provide information on health system performance.
  - Showcase information on leading practices to support knowledge transfer in health care quality improvement activities across Canada.
  - Engage the public to enhance awareness to the contribution of accreditation in improving quality and safety in our health care system.
- 4) Advancing innovative approaches to accreditation
  - Advance innovative approaches to accreditation to enable health care organizations to meet their quality improvement priorities while fostering performance.
  - Leverage technology as an enabler of quality improvement initiatives and knowledge sharing.
- 5) Functioning as a lean organization
  - Act in a fiscally responsible manner and demonstrate efficiency in the delivery of programs and services while maintaining integrity, relevance and rigour in the accreditation program.

### **Association of Faculties of Pharmacy of Canada (AFPC)**

The mission of pharmacy education is to provide programs of excellent quality which by their content and presentation produce graduates who contribute significantly to societal, professional and patient care responsibilities, and who are committed to life-long learning.

AFPC focuses on:

- A spectrum of educational programs is required in Canada, B.Sc., Residency, Pharm.D., M.Sc. and Ph.D., to provide graduates with the knowledge, skills and values needed to carry out these responsibilities with the goal of decreasing drug-related morbidity and mortality, promoting health and preventing disease;
- the direct patient care responsibility is the primary practice responsibility of pharmacists and this responsibility can be met through the provision of pharmaceutical care; and
- close cooperation among all pharmacy organizations (academic, licensing, voluntary) is required in all areas of education, including continuing education

### **Canadian Agency for Drugs and Technology in Health (CADTH)**

The strategic goals of CADTH are to cultivate an environment for evidence generation and adoption across Canada by acting as a broker and producer of health technology assessments that promote the optimal use of drugs and other health technologies. <sup>3</sup>

CADTH's key success factors are:

- 1) Customer satisfaction
- 2) Expanded use of evidence informed decision making in the management of health technologies.
- 3) Organizational efficiency

### **Canadian Association of Paediatric Health Centres (CAPHC)**

CAPHC has a five year (2014 – 2019) Strategic Plan. <sup>4</sup> This strategic plan reflects CAPHC's commitment to being a national voice for child and youth healthcare in Canada. The strategic priorities are:

- Support its members to make a difference in the healthcare outcomes of children.
- Be the voice for healthcare needs of Canada's children and youth.
- Develop impact metrics, a media and communications plan, and strengthen relationship with key thought leaders and organizations.

### **Canadian Association of Schools of Nursing (CASN)**

The three priorities that inform the direction of CASN are<sup>5</sup>:

- Demonstrate pan-Canadian leadership in nursing education, research and scholarship.
- Through education, research and scholarship, support the development of all nurses, fostering excellence and innovation for system transformation and sustainable healthcare.
- Collaborate with other partners on joint strategic initiatives to advance national education resources, quality and innovation.

The five strategic directions for 2014-2018 are:

- 1) Create a national framework for the CASN core mission of nursing education.
- 2) Advocate for better, more effective use of fiscal, strategic, and personnel resources for nursing education at provincial and national levels.
- 3) Support nursing schools and educators to deliver high quality nursing education across the span of nursing.
- 4) Foster the development of research and scholarship in nursing education to support disciplinary knowledge, nursing's contribution to interprofessional knowledge, and innovative quality healthcare.
- 5) Support the delivery of high quality nursing education through accreditation provincially, nationally, and internationally.

### **Canadian College of Health Leaders (CCHL)**

The Canadian College of Health Leaders (CCHL), formerly known as the Canadian College of Health Service Executives (CCHSE), is a national, member-driven, non-profit association dedicated to ensuring that the country's health system benefits from capable, competent and effective leadership.<sup>6</sup> The College has approved new strategic directions for 2015 – 2019.

The strategic directions of CCHL are:



- **Revolutionize: the CCHL Experience**  
Create an unparalleled experience with members and be seen as critical to the enablement of exciting and fulfilling career trajectories in health.
- **Stimulate: Transformative Thought**  
Challenge and disrupt traditional notions of leadership through ground-breaking research, passionate debate and innovative, tailored programs for members. Our thought leadership will contribute to meaningful system reform.
- **Generate: Networks of Influence**  
Connect local and global leaders by creating access to provocative, inspired and collaborative environments.

## Canadian Institute for Health Information (CIHI)

The Canadian Institute for Health Information (CIHI) 2012-2017 strategic goals are founded on a vision for CIHI's future of linking quality data to decisions and health outcomes.<sup>7</sup>

CIHI's Strategic Plan includes:

- 1) Improve the comprehensiveness, quality and availability of data

Over the next five years, CIHI will

- Provide timely and accessible data connected across health sectors
- Support new and emerging sources of data, including electronic records
- Provide more complete data in priority areas

- 2) Support population health and health system decision-making

Over the next five years, CIHI will

- Produce relevant, appropriate and actionable analysis
- Offer leading-edge performance management products, services and tools
- Respond to emerging needs while considering local content

- 3) Deliver organizational excellence

Over the next five years, CIHI will

- Promote continuous learning and development
- Champion a culture of innovation
- Strengthen transparency and accountability

## Canadian Foundation for Healthcare Improvement (CFHI)

The goals of the CFHI are:<sup>8</sup>

- Healthcare efficiency: Maximizing value for money in healthcare spending
- Patient- and family-centred care: Improving patient- and family-centred experience and outcomes
- Coordinated healthcare: Providing a more coordinated approach to complex health needs

## Canadian Society of Medical Laboratory Sciences (CSMLS)

The Canadian Society for Medical Laboratory Science (CSMLS) is the national certifying body for medical laboratory technologists and medical laboratory assistants, and the national professional society for Canada's medical laboratory professionals.<sup>9</sup> The purpose of CSMLS is to promote and maintain a nationally accepted standard of medical laboratory technology by which other health professionals and the public are assured of effective and economical laboratory services, and to promote, maintain and protect the professional identity and interests of the medical laboratory technologist and of the profession.

The four goals of CSMLS are:

- Engage and empower the profession
- Lead and partner to advance patient safety
- Enhance organizational capacity
- Expand our sphere of influence

## Canada Health Infoway

Canada Health Infoway (*Infoway*) released Opportunities for Action: A Pan-Canadian Digital Health Strategic Plan<sup>10</sup>. The plan, which details the health care priorities that digital health solutions can best support over the coming years, has identified key opportunities for action.

The strategic plan was developed in consultation with more than 500 Canadians, clinicians, government and health care administrators, national associations and digital health vendors, who were asked to identify priorities that health IT could best support. The six broad priorities are:

- 1) Healthy living
- 2) Access to care
- 3) Person Centred Care
- 4) Continuity of care
- 5) Quality improvement
- 6) Efficiency improvement

Six broad themes emerged describing health care priorities over the next several years, and from these themes, five opportunities for action were developed:

- 1) Bring care closer to home
- 2) Provide easier access
- 3) Support new models of care
- 4) Improve patient safety
- 5) Enable a high-performing health system

Much of *Infoway's* work over the past decade has concentrated on digital health investments in electronic health records and point-of-care systems for clinicians. These include solutions that securely house critical data including patient drug information, diagnostic images and lab test results, resulting in billions of dollars in health system efficiencies, improvements in access, and gains in quality of care.

Supporting safer care through the use of innovative digital health solutions was identified as a key opportunity for action in stakeholder consultations that inform Canada Health Infoway's plans and priorities. For example, *Infoway* co-invests with provinces, territories and others in solutions at the point of care (e.g., electronic medical records and clinical synoptic reporting); mechanisms to share core health information (e.g., medication profiles, test results and discharge summaries) with authorized clinicians through electronic health records; consumer health solutions; and other digital health solutions that have been shown to improve safety, such as computerized provider order entry. *Infoway* also works with partners – such as Accreditation Canada, CPSI, ISMP Canada and Canada's Health Informatics Association (COACH) – to improve understanding of how digital health can influence safety, share those learnings with the healthcare community and encourage adoption of best practices. One mechanism for doing so is the by-clinicians-for-clinicians Knowing Is Better campaign. In addition, *Infoway* encourages and incents healthcare providers to grow the use of digital health solutions that enable safer care and share their experiences with others through the ImagineNation Challenges. The recently completed Outcomes Challenge series focused on areas such as medication reconciliation and clinical synoptic reporting. The current eConnect Impact Challenge series is focusing on communication among healthcare providers and between providers and patients.<sup>11</sup>

## Canadian Home Care Association (CHCA)

The Canadian Home Care Association (CHCA) is a national not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to safely stay in their homes with dignity, independence, and quality of life. Members include governments, administration organizations, service providers, researchers, educators and others with an interest in home care.

The CHCA advances excellence in home care and continuing care through leadership, awareness, advocacy and knowledge.

The CHCA brings value to the home care sector and our members by:

- Increasing the understanding of the role and value of home care.
- Informing and influencing policy and practice.
- Initiating conversations that catalyze change.
- Facilitating continuous learning through partnerships and networks.

The Association's strategic priorities for 2014-16 include:

#### Home Care Knowledge Network

Building upon the framework of the Harmonized Principles for Home Care, the CHCA Knowledge Network will systematically identify, capture, interpret, share and re-frame new knowledge (based on research and experience). Through the network, organizations will gain access to new knowledge and change management strategies to adapt new models of care that result in better care, better outcomes and better value for investment.

#### Family Caregivers

Through our active involvement in the Canadian Caregiver Coalition and International Alliance of Carer Organizations, the CHCA will champion the well-being of family caregivers by advocating for the adoption and implementation of the elements of the Canadian Caregiver Strategy in legislation, policy and programming.

#### Safety at Home

Through collaborative partnerships the CHCA will advance a culture of safety by engaging clients, family caregivers and health care professionals to build an awareness and understanding of strategies and tools to prevent, identify and manage risk in the home setting. CHCA was a co-host of the Home Care Safety Roundtable held in June 2014.

#### Innovation

The CHCA will identify and stimulate innovative models of care and technology applications that facilitate an integrated, person-centered approach to health and wellness and support independence, safety and quality care in the home setting.

### Canadian Medical Association (CMA)

The CMA is a national, voluntary association of physicians that advocates on behalf of its members and the public for access to high-quality health care. The CMA also provides leadership and guidance to physicians. The CMA also takes the lead on public health issues. The CMA's goal is to ensure the survival and robust health of Canada's medicare system in the face of numerous challenges.

The high-level strategic directions of CMA are:<sup>12</sup>

#### The Profession

- Advance medical professionalism
- Improve physician health and well-being
- Strengthen the national voice of the CMA for the medical profession

#### Patients and the Public

- Lead a national vision for a healthy population and world-class health care
- Maximize strategic relationships

## Growth and Relevance

- Develop and market products and services that are highly responsive to member needs
- Increase member engagement, member satisfaction and membership growth

## Canadian Medical Protective Association (CMPA)

Incorporated by an Act of Parliament and founded in 1901, the Canadian Medical Protective Association (CMPA) is the only national not-for-profit, mutual defense organization committed to addressing the medical liability protection needs of Canadian physicians.

With the goal of supporting the safest possible healthcare system, and in collaboration with its members and other stakeholders, the CMPA leverages its understanding of medical risk to contribute to safe care. The CMPA also helps identify and reduce medical liability risks in physicians' practices through education, accredited courses and workshops. In addition, the CMPA provides advice and assistance to members facing medico-legal difficulties arising from the professional practice of medicine.

The CMPA will focus on three strategic outcomes, as defined in their 2015-2019 Strategic Plan:

- 1) Assisting physicians
- 2) Contributing to safe medical care
- 3) Supporting the medical liability system

A well-functioning healthcare system supports the availability of safe medical care for all Canadians, and providing effective and efficient medical liability protection is an essential component of this system.

## Canadian Nurses Association (CNA)

CNA is the national professional voice of registered nurses in Canada. A federation of 11 provincial and territorial nursing associations and colleges representing 151,404 registered nurses, CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.

The most recently available goals are from 2010-2014<sup>13</sup>:

- To promote and enhance the role of registered nurses to strengthen nursing and the Canadian health system.
- To shape and advocate for healthy public policy provincially/territorially, nationally and internationally.
- To advance nursing leadership for nursing and for health.
- To broadly engage nurses in advancing nursing and health.

To transform CNA governance structure and processes.

## Canadian Patient Safety Institute (CPSI)

The 2013-2018 CPSI Business Plan outlines four strategic goals to move patient safety forward in the Canadian healthcare system.<sup>14</sup>

- 1) The Canadian Patient Safety Institute will provide leadership on the establishment of a National

## Integrated Patient Safety Strategy.

- 2) The Canadian Patient Safety Institute will inspire and sustain patient safety knowledge within the system, and through innovation, enable transformational change.
- 3) The Canadian Patient Safety Institute will build and influence patient safety capability (knowledge and skills) at organizational and system levels.
- 4) The Canadian Patient Safety Institute will engage all audiences across the health system in the national patient safety agenda.

The National Integrated Patient Safety Strategy is the overarching strategy and will provide a framework for identifying priorities and aligning CPSI's work with the various players who are currently working separately to achieve patient safety gains in Canada. This will create the synergy and coordination required to accelerate improvement in patient safety in Canada as partners come together to integrate their collective efforts, informed by the voices of patients and families. In working with partners, more support was generated for developing a nation action plan for patient safety.

CPSI is also committed to working with partners, patients and families in elevating four priority areas of focus:

- 1) medication safety
- 2) surgical care safety
- 3) infection prevention and control
- 4) home care safety

These initial priorities will be tested through the multi-year Integrated Patient Safety Action Plan, with patient safety education being a foundational underpinning to advancing improvement.

## Patients for Patient Safety Canada (PFPSC)

Patients for Patient Safety Canada is a patient-led program of CPSI.<sup>15</sup> PFPSC is the voice of the patient (patients, clients, residents, customers, and family members (as defined by the patient)) and bring safety experiences to help improve patient safety at all levels in the health system.

The unique and valuable perspective of patients complements those of care providers, health leaders, policy makers, and managers of healthcare organizations and by working in partnership we help ensure that patient safety decisions and initiatives are truly patient-centred and result in safe care.

PFPSC works collaboratively with others to contribute at all levels in the healthcare system by:

- Sharing experiences, observations, and perspectives
- Representing the patient and family perspective in committees and working groups
- Identifying, initiating, sharing, and leading patient safety projects

As a program of CPSI, CPSI aims to have a patient or family member representative in 100% of CPSI programs.

## Infection and Prevention Control and Canada (IPAC Canada)

Infection Prevention and Control Canada is a multidisciplinary, professional organization for those engaged in the prevention and control of infections. IPAC Canada was incorporated under the Canadian Corporation Act in 1976 and is a registered non-profit organization. Infection Prevention and Control Canada has over 1600 members.

The 2016-2018 Strategic Plan states the following strategic goals<sup>16</sup>:

### Raise Leadership Profile

- 1.1 Increase public, government and organizational awareness of Infection Prevention and Control Canada
- 1.2 Improve the level and speed of responsiveness to issues
- 1.3 Increase political advocacy and influence
- 1.4 Establish an international presence

### Recalibrate Product Mix

- 2.1 Offer informed commentary on standards and guidelines across federal, provincial and territorial jurisdictions
- 2.2 Accelerate dissemination and distribution of audit tools
- 2.3 Enhance education emphasis to reflect fundamental infection and control principles
- 2.4 Continue to develop the CJIC as an indexed peer review journal

### Grow Capacity

- 3.1 Promote the value of Infection Prevention and Control Canada memberships to key target audiences
- 3.2 Make innovative use of technology to engage and educate
- 3.3 Expand mentorship
- 3.4 Build and leverage relationships with industry
- 3.5 Seek additional sources of funding

## Canadian Pharmacists Association (CPhA)

Innovation, advocacy, education, information and collaboration are some of the major areas the Canadian Pharmacists Association (CPhA) focuses on to support pharmacists and advance the profession by:

- Influencing decision makers on a wide range of medication safety issues
- Providing drug and therapeutic information for practice in innovative ways
- Coordinating professional development program
- Supporting national pharmacist network

## HealthCareCAN

HealthCareCAN fosters informed and continuous, results-oriented discovery and innovation across the continuum of healthcare. HealthCareCAN works with others to enhance the health of all Canadians; to build the capability for high quality care; and to help ensure value for money in publicly financed, healthcare programs. HealthCareCAN will focus on three Key Result Areas (KRAs):<sup>17</sup>

- Advancing Science and Technology in Service of Health;
  - 1) Advocating for sufficient funding and favourable policy for the generation and use of research and innovation;
  - 2) Expediting the spread and translation of research and innovation in collaboration with members and partners such as the Canadian Institutes of Health Research; and,
  - 3) Advancing national recognition of the leadership, best practice, research excellence and enterprise of HealthCareCAN members.
- Supporting Service Excellence; and,
  - 1) Securing strategic investments and policy support for healthcare innovations aimed at priority areas, including helping vulnerable people of Canada;
  - 2) Advancing the generation, dissemination and adoption of knowledge and innovative practice by convening health stakeholders; and,
  - 3) Creating one advocacy voice for the full continuum of healthcare delivery organizations across Canada, influencing federal, provincial and territorial governments and advisory bodies.
- Developing People.
  - 1) Providing comprehensive management education programs that provide emerging health leaders and middle managers with the capabilities to manage the complexities of today's health system;
  - 2) Fostering access to a broad array of high-quality, accessible, and relevant professional development products that support the highest standard of healthcare excellence at all levels of the health system, from functional manager, to emerging health leader, to governor; and,
  - 3) Providing an education system and environment that is sustainable and learner-focused, that provides an exceptional experience and facilitates ongoing and continuous learning.

### Healthcare Insurance Reciprocal of Canada (HIROC)

HIROC is Canada's leading provider of healthcare liability insurance. As a not-for-profit organizations with subscribers to provide innovative insurance and risk management solutions that help them reduce risk, prevent losses and improve patient safety.<sup>18</sup>

In an effort to learn from failures, HIROC developed a list of the top (primarily clinical) risks in acute care, non-acute care and midwifery based on total claims costs. In terms of priorities, in acute care, three of the top ten risks relate to obstetrics; failure to identify deteriorating patient status is a risk seen across the continuum of care. For each of the top risks, a Risk Reference Sheet was developed including risk mitigation strategies. Subscribers are able to assess their compliance using the online Risk Assessment Checklists program. Aggregate analysis enables HIROC to identify higher and lower scoring clinical risks and mitigation strategies across the healthcare system.

The Risk Register is HIROC's integrated risk management solution. The Risk Register is a shared online platform that enables subscribers to identify, assess and manage crucial information related to a broad range of risks impacting key organizational/strategic objectives. These can then be analyzed at an aggregate level by HIROC yielding data on top organizational risks across the healthcare system.



## **Institute for Safe Medication Practices Canada (ISMP Canada)**

An organization strategic plan was not available from the ISMP Canada website. However, the purpose and high level goals are provided below.<sup>19</sup>

### **Purpose**

To identify risks in medication use systems, recommend optimal system safeguards, and advance safe medication practices.

### **Goals**

- To review and analyze medication incident and near-miss reports according to a hazard identification model, identify contributing factors and causes and make recommendations for the prevention of harmful medication incidents.
- To promote safe medication use and system strategies for reduction of adverse drug events.
- To publish and disseminate information on safe medication practices for knowledge translation.
- To develop and provide tools and educational programs for building capacity to enhance patient safety.
- To provide expertise and consultation on medication systems in health service organizations and other health care settings.
- To develop quality improvement programs for use by the healthcare community.
- To work with regulatory agencies, policy makers and manufacturers to promote enhancements to pharmaceutical product packaging and labelling.
- To facilitate patient safety research.
- To establish and maintain strong partnerships with the Institute for Safe Medication Practices (ISMP) in the US, and other key national and provincial organizations with an interest in patient safety.
- To achieve the outcomes envisioned by the Canadian Medication Incident Reporting and Prevention System (CMIRPS), a collaborative initiative of ISMP Canada, the Canadian Institute for Health Information (CIHI) and Health Canada (known as the collaborating parties for CMIRPS), in conjunction with the Canadian Patient Safety Institute (CPSI).

ISMP Canada was a co-host of the Medication Safety Summit held in June 2014.

## **Mental Health Commission of Canada (MHCC)**

The MHCC is funded by Health Canada and has a 10-year mandate (2007-2017). Among its initiatives, the MHCC's work includes the country's first mental health strategy, working to reduce stigma, advancing knowledge exchange in mental health, and examining how best to help people who are homeless and living with mental health problems.<sup>20</sup>

## Patients Canada

Patients Canada is a patient-led organization that fosters collaboration between patients, family caregivers and the healthcare community. The main programs and activities include:

- Working with partners to help them become more patient centred
- Supporting patient engagement
- Working on service redesign with partners
- Acknowledging what works in our system now
- Participating in research from the patients' point-of-view
- Discussions with healthcare thinkers and policy makers

## Royal College of Physicians and Surgeons Canada (RCPSC)

The RCPSC sets the highest standards for specialty medical education in Canada. Lifelong learning for specialist physicians is supported and promoting sound health policy. In carrying out the mandate, the following are among core tasks:

- Accreditation-Residency programs at 17 universities across Canada and also accreditation of the learning activities that physicians pursue in their continuing professional development programs.
- Credentials-Verify that a physician has met all the requirements necessary for Royal College certification
- Examination-With volunteer Fellows, we produce and administer the national certification exams
- Maintenance of Certification- to meet the lifelong learning needs of Fellows and other physicians
- CanMEDS- with the goal of improving patient care.

## The Academy of Canadian Executive Nurses (ACEN)

ACEN's objectives are to<sup>21</sup>:

- Influence and participate in setting the directions for health care policy and dialogue in Canada.
- Contribute to the alignment and advancement of the national nursing practice, education, research, and leadership agendas.
- Develop strong strategic coalitions and partnerships with other health care leadership groups
- Support the development of current and emerging executive nurse leaders in Canada
- Provide a forum to discuss and share strategies related to nursing, education, research and leadership
- Support the editor and the editorial board in providing the Canadian Journal of Nursing Leadership.
- National Nursing Quality Report.

In the fall of 2010, the Academy of Canadian Executive Nurses (ACEN) Leadership/Policy Committee made the decision to focus on identifying and promoting significant nurse sensitive indicators. The committee chose this initiative in order to make explicit the contribution of nursing to quality health outcomes, as well as to envision a report card that could be used to formulate and drive the quality agenda in the future. The committee contacted researchers in the field and key stakeholders involved in outcome measurement, including Canadian Nurses Association (CNA), Canada Health Infoway and the Canadian Institute of Health

Information (CIHI). The idea for a national nursing report card was solidified and an invitational Think Tank was convened to launch this work. ACEN and CNA agreed to co-chair a Planning Committee for the Think Tank event to select and define nurse sensitive structure, process and outcome indicators. Funding was solicited from Health Canada for the think tank meeting and the follow-up work. The CPSI Patient Safety Metrics system is used to collect data.

## The College of Family Physicians of Canada

The mission of The College is to support family physicians through certification, advocacy, leadership, research, and learning opportunities that enable them to provide high-quality health care for their patients and their communities.

### Goals

- Quality patient-centred care
- Rewarding and valued careers
- Relevant and progressive educational standards
- Research capacity
- Organizational effectiveness
- Social accountability and equity

## Federal/Provincial/Territorial Priorities in Patient Safety and Quality

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The following section is a high level overview of federal, provincial and territorial department of health priorities. The strategic priorities for the individual quality councils are also described, as well as some provincial organizations with a patient safety mandate. Implementation of the Integrated Patient Safety Action Plan will require the involvement, feedback, and expertise of the departments of health and quality councils. Where appropriate, public reporting of patient safety indicators is briefly described. A summary of provincial legislation follows in the next section.

### Federal Priorities in Patient Safety and Quality

#### Canadian Institutes for Health Research (CIHR)

CIHR's strategic priorities and goals for 2014/15 to 2018/19 are:<sup>22</sup>

- Strategic Direction 1: Promoting Excellence, Creativity and Breadth in Health Research and Knowledge Translation
  - Build a solid foundation for the future
- Strategic Direction 2: Mobilizing Health Research for Transformation and Impact
  - Refresh health and health system research priorities
  - Reaping benefits through strategic alliances
  - Building an entrepreneurial advantage
  - Embracing the data revolution
- Strategic Direction 3: Achieving Organizational Excellence

## Health Canada

An overall strategic plan for Health Canada was not found, however the strategic plan for the Health Products and Food Branch Strategic for 2012-2015 is:<sup>23</sup>

### Priority No. 1: The Regulatory Roadmap

The goal of this priority is to build a sustainable regulatory system that helps to protect the Canadian public from the sale and advertising of unsafe food and health products, and to support the safest consumption of food and use of health products, well into the future.

### Priority No. 2: Operational Excellence

The goal of this priority is to set, meet, and ultimately exceed our performance standards, while working more effectively with staff, Canadians, international partners, and stakeholders.

### Priority No. 3: The People Agenda

The goal of this priority is to create and support a high performing and collaborative team working towards the strategic priorities of the Branch.

## Public Health Agency of Canada (PHAC)

The most recent publicly available strategic plan for PHAC is from 2007-2012.

The role of the PHAC is to:

- Promote health;
- Prevent and control chronic diseases and injuries;
- Prevent and control infectious diseases;
- Prepare for and respond to public health emergencies;
- Serve as a central point for sharing Canada's expertise with the rest of the world;
- Apply international research and development to Canada's public health programs; and

Strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning.

## Provincial/Territorial Priorities in Patient Safety and Quality

### Alberta

#### Alberta Health

The Government of Alberta has published a five year health action plan released in November 2010. The five main strategies are below with specific references and/or stated actions related to patient safety included:

- 1) Be Healthy, Stay Healthy
- 2) Strengthen Primary Health Care
- 3) Improve Access and Reduce Wait Times
  - a. Goal #1: Improved quality, safety and access for patients to acute care services will be demonstrated by lower wait times across the province.
- 4) Provide More Choice For Continuing Care
- 5) Build One Health System<sup>24</sup>
  - Improve public and patient safety
    - Establish a Patient Safety Framework to guide and support patient safety in Alberta (complete)
    - Improve provincial standards for prevention and control of infections in health-care facilities
    - Develop and deliver courses on patient safety throughout the province
    - Publicly report on performance and compliance with standards
    - Benefits to Albertans: There will be fewer patient safety incidents in health-care facilities in the province
  - Merge and standardize operating systems
    - Benefits to Albertans: Reliable information will be collected and used to improve patient safety

Regular progress updates are posted on the Government of Alberta website.

Alberta's Health Charter<sup>25</sup> (2014) states that when Albertans interact with the health system they can expect that they will "have timely and reasonable access to safe, high quality health services and care".

## **Alberta Health Services**

Alberta Health Services' 2014-2017 Health Plan and Business Plan<sup>26</sup> guides and outlines the organization's operational goals over the next three years based upon three strategic directions:

- 1) Bringing appropriate care to community
- 2) Partnering for better health outcomes
- 3) Achieving health system sustainability

Alberta Health Services is utilizing the Alberta Health Matrix for Health, developed by the Health Quality Council of Alberta to focus on their strategic directions. More specifically, the AHS Quality and Patient Safety Strategic Outline<sup>27</sup> list the following key enablers (each of which is linked to organizational strategies and performance measures):

- Patients as Partners
- Skilled People and a Supportive Culture
- Accountability through Measurement and Evaluation
- Access

Alberta Health Services has committed to publishing performance reports on 16 performance measures, which include patient safety measures of: C difficile rates, hand hygiene compliance, and hospital mortality. The first report was publicly published in January 2014, with public reporting of these measures occurring quarterly.

## **Health Quality Council of Alberta (HQCA)**

While the HQCA's responsibilities are set forth in the *Health Quality Council of Alberta Act*<sup>28</sup>, the work of the HQCA is guided by a strategic framework. The Strategic Framework for 2015-2018 outlines four organizational strategies and along with the HQCA's business plan, describes how the organization will achieve its legislated mandate to promote and improve patient safety and health service quality across Alberta. The four key strategies from the 2015-2018 HQCA Strategic Framework<sup>29</sup> are:

- 1) Build capacity —Enable high quality and safe patient care by assisting stakeholders at multiple levels to develop skills in system improvement.
- 2) Measure to improve—Measure, analyze and report on healthcare deliver to drive actionable improvement that enhances the quality of healthcare for Albertans.
- 3) Monitor the health system—Monitor and report on health system level indicators to characterize health system performance over time and enable comparison where appropriate.
- 4) Partner with the public—to support and enable effective citizen participation in their healthcare and the healthcare system.

## British Columbia

British Columbia has required reporting on Hand Hygiene, CDI, and MRSA through the Provincial Infection Control Network of British Columbia (PICNet).<sup>30</sup> PICNet is a provincial program of the Provincial Health Services Authority (PHSA) with a specific interest in the prevention and control of healthcare associated infections. The key areas include surveillance, guidelines and education. PICNet works together with partners on province-wide surveillance initiatives, development and promotion of evidence-based best practices, and the creation of educational and operational tools.

### British Columbia Ministry of Health Services

The British Columbia Ministry of Health Services has 2015-2018 Service Plan with three strategic goals<sup>31</sup>:

1. Support the health and well-being of British Columbians
2. Deliver a system of responsive and effective health care services across British Columbia
3. Ensure value for money

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### British Columbia Patient Safety and Quality Council (BCPSQC)

In April 2008, the British Columbia (BC) Minister of Health Services established the British Columbia Patient Safety and Quality Council. The current strategic priorities (2012-2015) are<sup>32</sup>:

- Fostering a province wide perspective
- Advancing capability and capacity for improvement
- Accelerating improvement
- Improving transparency
- Fostering a quality culture
- Creating value

Current initiatives include supporting BC Ministry of Health Clinical Care Management program by leading collaboratives and networks, working with medical and health profession schools to develop quality approaches in curricula, and developing province wide learning programs in order to continue to grow B.C.'s quality improvement community.

## Manitoba

### Manitoba Health, Healthy Living and Seniors (MHLS)

As early as 2003, MHLS encouraged the voluntary reporting of critical clinical occurrences (now called "critical incidents") where learning might occur from seemingly isolated errors. In 2006, legislation was introduced for mandatory no-blame critical incident reporting across the health system to support a culture of learning and openness. Manitoba was the second province to introduce mandatory reporting and investigation of critical incidents.

There are several initiatives underway in the health care system to improve patient safety, including making changes to deliver safer care, to better enforce infection prevention and control measures, and to facilitate better communication between health care providers and patients and their families.

Since 2010/11, MHLS has been committed to integrating Lean Management into ongoing health system improvement.<sup>33</sup> Lean Management is a quality improvement methodology that has been implemented in

various Canadian provinces to improve health care efficiency. The Manitoba-specific Lean Strategy is a province-wide five-year training and mentoring strategy. The aim of this strategy is to deliver training in system efficiency and quality improvement to Manitoba Regional Health Authorities (RHAs) and health system stakeholder agencies. The initial goal for the five-year strategy was to train over 1600 health care staff and implement a minimum of 225 improvement projects resulting in anticipated minimum savings of \$4.1 million.

In Year 2, MHLS provided the funding and coordination to establish a Green Belt network to foster a community of practice to support Lean. In Year 3, a Black Belt network was also created to bring together health providers trained at the Black Belt level. The Green Belt and Black Belt networks are unique to Manitoba Health, and are an innovation in implementing Lean Management in health systems.

### **Manitoba Institute for Patient Safety (MIPS)**

In 2004, the Manitoba government established the Manitoba Institute for Patient Safety (MIPS). This independent, non-profit organization promotes and co-ordinates activities to improve patient safety and the quality of health care for Manitobans. MIPS, coordinates and facilitates activities that have a positive impact on patient safety throughout Manitoba while enhancing the quality of healthcare for Manitobans.

Areas of priority include:

- Resources -develop, share, promote
- Education - conduct, promote competency development, sponsor
- Policy/Legislation - advise on patient safety related policy and legislation
- Awareness building - of MIPS and patient safety issues
- Operational objectives for 2015-16 include: Build capacity for practicing safely by encouraging adoption of leading practices with MIPS members, healthcare providers, leaders, governors and healthcare organizations
- Raise awareness of patient safety issues by reaching out to the public, MIPS members, healthcare providers/organizations through collaboration and communication vehicles
- Engage patients and families by educating and supporting the public in learning to advocate for themselves and other for safe healthcare

### **Newfoundland and Labrador**

The Department of Health and Community Services has a 2014-2017 Strategic Plan that outlines the priorities for three years.<sup>34</sup> The three strategic priorities are outlined below.

#### **Strategic Issue One: Population Health**

Goal 2014-17

- By March 31, 2017, the Department of Health and Community Services will have improved its capacity to contribute to positive health outcomes for the people of the province.
- Measure: Improved capacity to contribute to positive health outcomes for the people of the province
- Indicators:
  - Enhanced legislative and policy frameworks
  - Improved capacity building initiatives in the population health system



- Implemented public awareness initiatives towards improving population health
- Increased collaboration and stakeholder engagement to advance and inform initiatives in key areas of population health
- Objectives 1 - By March 31, 2015, the Department of Health and Community Services will have assessed its current capacity in select areas of population health.
- Measure: Assessed the Department's current capacity in select areas of population health
- Indicators:
  - Reviewed current health promotion and wellness policies, programs and services
  - Identified areas to support improved development and delivery of health promotion in the province
  - Identified areas for increased collaboration and stakeholder engagement to advance and inform initiatives in key areas of population health
  - Initiated renewal of select policy frameworks
- Objective 2- By March 31, 2016, the Department of Health and Community Services will have implemented initiatives that contribute to positive health outcomes.
- Object 3- By March 31, 2017, the Department of Health and Community Services will have evaluated the implementation of select legislative and policy frameworks that contribute to the overall health of the population.

## **Strategic Issue Two: Access to Priority Service**

### Goal

- By March 31, 2017, the Department of Health and Community Services will have improved access to priority health and community services.
- Measure: Improved access to priority health and community services
- Indicators:
  - Enhanced long-term care and community support services
  - Implemented innovative e-health solutions to improve access while enhancing efficiency within the system
  - Reduced wait times in key areas such as orthopedic services, endoscopy services, emergency departments and services for children with developmental disabilities including autism
  - Increased access to mental health and addictions programs and services for adults, children and youth
  - Explored options to improve access to primary health care services in the community
- Objectives 1- By March 31, 2015, the Department of Health and Community Services will have implemented initiatives aimed at improving access to priority health and community services.
- Measure: Implemented initiatives aimed at improving access to priority health and community services
- Indicators:
  - Implemented various initiatives towards enhancing long term care and community support services
  - Identified initiatives to reduce wait times in services for children with developmental disabilities
  - Implemented initiatives to reduce wait times in endoscopy services, orthopedic surgery and emergency departments

- Completed Phase 2 of an anti-stigma awareness campaign for mental health and addictions
- Objective 2 - By March 31, 2016, the Department of Health and Community Services will have continued to implement changes and enhancements towards improving access to priority health and community services.
- Objective 3 - By March 31, 2017, the Department of Health and Community Services will have evaluated key priority areas of access and identified areas for performance improvements.

### **Strategic Issue Three: Quality of Care and Efficiency**

#### Goal 2014-17

- By March 31, 2017, the Department of Health and Community Services will have improved capacity to strengthen quality of care and achieved efficiencies in the provincial health and community services system.
- Measure: Improved capacity to strengthen quality of care and achieved efficiencies
- Indicators:
  - Implemented quality improvements
  - Monitored implementation of operational improvement initiatives to ensure efficiencies realized
  - Explored further opportunities for operational efficiencies within the health and community services system
  - Monitored implementation of clinical efficiency reviews
  - Implemented initiatives towards enhancing patient safety
  - Enhanced the provincial ambulance program
- Objective 1- By March 31, 2015, the Department of Health and Community Services will have initiated implementation of systems and processes towards improved quality of care and efficiency within the provincial health and community services system.
- Measure: Initiated implementation of systems and processes towards improved efficiency and quality of care within the health and community services system
- Indicators:
  - Implemented select recommendations from the ambulance review implementation plan
  - Developed the implementation plan for the Electronic Medical Record (EMR)
  - Worked with RHAs to review and identify improvements in clinical service delivery to optimize patient care and resource efficiency
  - Established consistent performance indicator reporting, in select areas, from RHAs towards improved data quality
  - Identified initiatives to enhance patient safety
- Objective 2 - By March 31, 2016, the Department of Health and Community Services will have continued monitoring and implementing systems towards improved quality and efficiency.
- Objective 3 By March, 31, 2017, the Department of Health and Community Services will have evaluated changes within the health and community services system and identified areas for performance improvements.

## New Brunswick

### Government of New Brunswick

The province published a provincial health plan called “Rebuilding Health Care Together: The Provincial Health Plan 2013-2018.”<sup>35</sup> The goal of the health plan is to build a long-term sustainable, effective and efficient health-care system.

The plan is based on seven principles for re-building the provincial health system:

- **Access:** The ability of patients or clients to obtain the right care or service at the right place and the right time, based on respective needs, in the official language of their choice;
- **Appropriate Range of Services:** The care or service provided is relevant to the patients’ or clients’ needs and based on established standards;
- **Effective:** The care, service, intervention or action achieves the desired results;
- **Efficient:** Achieving the desired results with the most cost-effective use of resources;
- **Equitable:** Aiming for equitable care and services for all;
- **Safe:** Potential risks of an intervention or the environment are avoided or minimized;
- **Clinically Sustainable:** Programs include at least four or five providers, with sufficient volume to maintain clinical expertise.

### New Brunswick Health Council (NBHC)

The New Brunswick Health Council has a dual mandate of engaging citizens and reporting on health system performance. The main areas of focus are the following:

- **Population health:** What is the health status of the population?
- **Quality of services:** How effective are health services?
- **Sustainability:** Is the health system sustainable?

The New Brunswick Health Council fosters transparency, engagement, and accountability by:

- Engaging citizens in a meaningful dialogue.
- Measuring, monitoring, and evaluating population health and health service quality.
- Informing citizens on health system’s performance.

Goals:

- Conduct care experience surveys (home care 2012; acute care 2013; and primary health survey 2014 to assess progress from baseline results three years ago); and compile and disseminate system report cards.
- Launch and support public website with population health snapshots provincially and by health zone: My Community at a Glance.

## Northwest Territories (NWT)

The NWT Department of Health and Social Services has published a 2011-2016 Strategic Plan.<sup>36</sup> The plan outlines six key priorities for the territory:

- Priority 1: Enhance services for children and families
- Priority 2: Improve the health status of the population
- Priority 3: Deliver core community health and social services through innovative service delivery
- Priority 4: Ensure one territorial integrated system with local delivery
- Priority 5: Ensure patient/client safety and system quality
- Priority 6: Outcomes of health and social services are measured, assessed and publicly reported

The NWT Health and Social Services Performance Measurement Framework (the Framework)<sup>37</sup> was published in May 2015 as well as the Public Performance Measures Report 2015 (the Report).<sup>38</sup> The Framework is the first in Canada to incorporate both health services and social services into one comprehensive framework. Within the Framework the system outcomes that fall under the system goal “Best Care” include: patient/client centred, culturally relevant, appropriate, accessible, effective, efficient, and safe. The Report is intended to track and measure the performance of the NWT HSS system as it relates to improving the overall health status of the NWT. The 2015 Report does not include indicators specifically related to patient safety.

## Nova Scotia

### Strategic Goals of the Nova Scotia Health System

The Nova Scotia Department of Health and Wellness has the following four strategic goals included in the 2015-16 Statement of Mandate<sup>39</sup>:

**Health System Goal #1: Health of the Population** - Improve the health and wellness of Nova Scotians through health promotion, disease and injury prevention, enhanced primary health care and culturally competent chronic disease management

The two 2015-16 priority areas for action under this strategic goal are:

- 1) Strategic Priority: Improvement in, and more use of, community focused care for seniors and patients with chronic conditions
- 2) Strategic Priority: Creation of supportive environments to promote the health of all Nova Scotians

**Health System Goal #2: Health System Workforce** - A workplace culture that fosters leadership, competence, collaboration and engagement.

The two 2015-16 priority areas for action under this strategic goal are:

- 1) Strategic Priority: Optimal mix and distribution of health professionals working collaboratively to achieve the most effective and cost-efficient health system
- 2) Strategic Priority: Employee engagement focused on promoting leadership, competence, productivity and collaboration

**Health System Goal #3: Experience of Care** - Access to quality, evidence-informed, appropriate care.

The two 2015-16 priority areas for action under this strategic goal are:

- 1) Strategic Priority: More coordinated team-based primary care, giving patients comprehensive non-acute services from practitioners, such as doctors, nurses, nurse practitioners, dietitians and physiotherapists
- 2) Strategic Priority: Increased use of evidence and data to inform planning and system learning to improve safety and service delivery

**Health System Goal #4: Resource Stewardship** - Sustainable actions that support learning, research, innovation and effective use of resources

The three 2015-16 priority areas for action under this strategic goal are:

- 1) Strategic Priority: Expanded development and use of innovative technologies and strategies
- 2) Strategic Priority: Appropriate use of resources to achieve high performance outcomes
- 3) Strategic Priority: Streamline administration and efficient and effective use of resources in the health system

The Government of Nova Scotia passed the *Patient Safety Act* in May 2012.<sup>40</sup> The act requires hospitals to collect patient safety indicators and report the results to the Department of Health and Wellness and the public. Since May 2013, the District Health Authorities and the IWK Health Centre report on:

- How often are healthcare workers are cleaning their hands- expressed as a percentage from observations by hand hygiene auditors, before and after contact with patient/environment
- How often patients get *Clostridium difficile* infection while in hospital- expressed as a rate per 10,000 patient days.

In January 2014, health care professionals at the Nova Scotia Health Authority and the IWK Health Centre began providing information to the province on serious events in accordance with the Serious Reportable Event Interim Reporting Policy. By monitoring, measuring and evaluating reportable event data, Nova Scotia is enhancing their patient safety improvement efforts and identifying opportunities for system-wide improvements.<sup>41</sup>

## Ontario

### Ministry of Health and Long Term Care (MOHLTC)

Released in early 2015, Patients First: Action Plan for Health Care is the next phase of Ontario's plan for changing and improving Ontario's health system, building on the progress that's been made since 2012 under the original Action Plan for Health Care.<sup>42</sup>

The first Action Plan for Health Care promised to help build a health care system that was patient-centered. Patients First is the blueprint. It builds on that commitment and sets the framework for the next phase of health care system transformation. It is designed to deliver on one clear health promise – to put people and patients first by improving their health care experience and their health outcomes.

This plan focuses on four key objectives:

- Access : Improve access – providing faster access to the right care.

- Connect : Connect services – delivering better coordinated and integrated care in the community, closer to home.
- Inform : Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
- Protect : Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.

## Health Quality Ontario (HQO)

The Health Quality Ontario (HQO) 2015-2018 Business Plan<sup>43</sup> highlights five specific priorities the organization will focus on over the coming years that reflect their core mandate:

- Priority 1: Continue to establish our role as the province's advisor on health care quality.
- Priority 2: Work with the system to actively improve quality of care.
- Priority 3: Involve patients, family, and the public in the quality agenda.
- Priority 4: Expand and enhance our communications to make HQO the recognized voice of health care quality in Ontario.
- Priority 5: Work as an integrated, high-performing organization.

In Ontario, indicators are publicly reported for acute care, long term care, home care, and there is an overall report on health system performance produced by HQO (see Appendix A). A comprehensive framework to measure primary care performance at both the practice and system levels has been developed and works to develop the plan and infrastructure that address performance measurement barriers and gaps.<sup>44</sup>

The nine hospital-based patient safety indicators that are legislated to be publicly reported include<sup>45</sup>:

- Methicillin-resistant Staphylococcus aureus (MRSA) rate
- Vancomycin-resistant Enterococci (VRE) rate
- Clostridium difficile (C. difficile)
- Hospital-Standardized Mortality Ratio (HSMR)
- Ventilator-Associated Pneumonia (VAP) rate
- Central Line-Associated Primary Blood Stream Infection (CLI) rate
- Surgical Site Infection (SSI) prevention rate in hip and knee joint replacement surgeries
- Hand Hygiene Compliance- expressed as a percentage from observations by hand hygiene auditors, before and after contact with patient/environment
- Surgical Safety Checklist compliance

HQO publicly reports on 11 quality indicators for home care services at the provincial level and Community Care Access Centre (CCAC) level: waiting for nursing service, waiting for personal support services for complex care patients, hospital readmissions, incontinence, communication, falls, pressure ulcers, long term care placement, emergency department visits, and vaccination.<sup>46</sup> One indicator, patient satisfaction, is also reported on at the service provider organization level.

HQO publicly reports on 11 indicators related to the quality of the long-term care system at the provincial level: wait times, incontinence, activities of daily living, cognitive function, pain, falls, pressure ulcers, restraint use, medication safety, health human resources and infection rates.

HQO report on four indicators for individual long-term care homes: falls, incontinence, pressure ulcers and restraint use, which are measured against benchmarks.

Measuring Up 2015 is the current yearly report from Health Quality Ontario that looks at the health of Ontarians and how Ontario as a health system is performing. The report is based on a set of indicators developed with experts across the province called the Common Quality Agenda.<sup>47</sup> These measurements reflect how the quality of care is changing in Ontario — how each region is performing, and how Ontario compares with the rest of Canada and other countries. The report covers a range of health topics and spans all health care sectors from primary care to hospital care, home care and long-term care.

HQO has launched an initiative entitled Quality Matters: Realizing Excellent Care for All.<sup>48</sup> HQO states this is part of their ongoing effort to unite everyone in the (Ontario) health system through a common language of quality and to reach a shared commitment to take action on common goals. As part of this initiative, HQO has released a report Realizing Excellent Care For All, that articulates a vision for improving quality in health care. It offers six domains of quality (safe, effective, patient centred, efficient, timely, equitable), a set of principles, and key factors needed to instill quality at the core of (the Ontario) health system.

### **Ontario Hospital Association**

The Ontario Hospital Association (OHA) 2013-2017 Strategic Plan: A Catalyst for Change, outlines three strategic directions for the organization as well as set of OHA performance indicators they will use to measure their own progress.<sup>49</sup>

The three strategic directions are:

1. Advancing Integrated Care with the goal to achieve a seamless patient experience.
2. Realizing Quality with the goal to advance high quality patient care.
3. Delivering value with the goal to drive system performance.

The OHA is a key resource for Ontario hospitals that function within an increasingly complex legislative framework for quality and patient safety in Ontario where many Acts intersect with one another.<sup>50</sup> The OHA has developed a number of backgrounders, updates, submissions, FAQs and toolkits, all designed to provide relevant and timely information on legislative and regulatory issues.

### **Prince Edward Island (PEI)**

Health PEI is Prince Edward Island's single provincial health authority. Health PEI is responsible for the delivery and management of all PEI health services.

Health PEI has published a 3 year Strategic Plan outlining the health system direction for 2013-2016. This Strategic Plan has 3 areas of focus:

1. Quality
  - ensuring appropriate patient safety standards are met
  - embedding patient centered care
  - promoting improved health outcomes through prevention and education
  - fostering a healthy work environment
2. Access
  - reducing wait times in key areas such as primary care, emergency departments, long term

care, elective surgery, and mental health/addiction services.

- improving access for vulnerable populations including frail elderly and children with complex needs.
- Efficiency
  - utilize technology to improve quality and safety
  - improve patient flow in health system
  - improved coordination of care
  - effective resource management

Regular updates via annual reports are available on the Health PEI website.

Health PEI Quality and Safety Committee is a subcommittee of the Health PEI Board of Directors. This committee includes two public members. The Committee meets several times each year to receive reports from 19 provincial quality teams. These teams are monitoring quality and performance measures across all aspects of the health system.

## Saskatchewan

### Ministry of Health and Health System

The 2015-16 Health Plan for the Ministry of Health and Health System is organized by four strategies: Better Health, Better Care, Better Value, and Better Teams.<sup>51</sup> The plan outlines overall Government goals, Ministry goals, strategies and performance measures. Patient safety related content in the plan is highlighted below:

- Ministry Goal: Improve population health through health promotion, protection and disease prevention, and collaborating with communities and different government organizations to close the health disparity gap.
  - Key action: Better meet the needs of long-term care residents and improve quality outcomes and resident safety by starting to implement Purposeful Rounding in all health regions.
- Ministry Goal: In partnership with patients and families, improve the individual's experience, achieve timely access and continuously improve healthcare safety
- Ministry Goal: Build safe, supportive and quality workplaces that support patient and family-centred care and collaborative practices, and develop a highly skilled, professional and diverse workforce that has a sufficient number and mix of service providers
  - Strategy: Culture of Safety—By March 2020, there will be no harm to patients or staff
    - Key actions: Stop the Line (STL) is a process that not only allows, but expects, anyone who encounters a hazard to report it immediately. In 2015/16, STL will be replicated at Saskatoon City Hospital and Royal University Hospital
    - Support all RHAs to prepare for STL implementation by conducting a readiness assessment and addressing any gaps
    - Full implementation of the Safety Management System

### Health Quality Council (HQC) (Saskatchewan)

The three main initiatives of HQC are:

- Measuring quality of care: Providing information for learning and improvement
- Continuous improvement (Lean): Improving how care is managed and delivered



- Improving surgical, primary health care: Making care better and safer for patients

The HQC leads or supports the following priority initiatives in the province:

- Setting Strategy
- Coordinating and Building Capability for Improvement
- Measuring Quality of Care
- Safety Alert/Stop the Line
- Patient and Family-Centered Care
- Health System Research
- Appropriateness of Care

The Saskatchewan's Health Quality Council has created the Quality Insight website, which regularly updates the public on the province's healthcare performance.<sup>52</sup> Indicators include patient satisfaction in hospital, as well as a suite of indicators on Saskatchewan's Surgical Initiative, such as wait times HSMR data, readmissions for hysterectomy and prostatectomy, medication reconciliation compliance, and completion of best possible medication history. The website has a searchable feature for each of 13 health regions.

## Yukon

The Yukon Government has a Health and Social Services Strategic Plan for 2014-2019.<sup>53</sup> The Departmental Goals are:

1. Optimal physical and mental wellbeing
2. Safety and wellbeing for vulnerable/'hard-to-serve' populations
3. Access to integrated, quality services

The Corporate Goals are:

1. Talented people are recruited, developed, and engaged to provide high quality service to the public
2. Practice open, accountable, and fiscally responsible government
3. Strategic corporate initiatives are advanced through interdepartmental cooperation

Yukon Health and Social Services published the HSS Performance Measure Framework: 2014 – 2019.<sup>54</sup> The Framework aligns to the six strategic goals noted above and includes annual and five year measures.

More specifically to key strategic quality and safety initiatives, the Department is currently implementing an Incident Management system.

## Atlantic Health Quality and Patient Safety Collaborative

The priorities for 2015-2017 (pending endorsement by the four Atlantic Deputy Ministers) are:

- Collaboration with CPSI to plan and execute an Incident Management training program
- Collaboration with CPSI on the creation of a Guide for Engaging with Patients and Families in Patient Safety (an action from the Consortium action plan)
- Atlantic Quality and Patient Safety Learning Exchange May 2017

## Key Legislation

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As discussed at the January 27, 2014 meeting of the National Patient Safety Consortium, and as seen in the scan on leading large scale change, a key component of advancing patient safety at a national scale is the implementation of legislation. CPSI contacted a health policy expert and trained lawyer in 2012 to conduct a review of legislation for quality improvement, mandatory disclosure and mandatory reporting, and apology protection legislation. These reviews were updated in the Spring 2015. The summary table on Patient Safety and Quality Legislation (Table 1) of findings can be found in this section.

### Legislation on Provincial Patient Safety and Quality Councils

As described above, several provinces have formal patient safety and/or quality councils that are advancing healthcare improvement. In total, seven provinces have quality agencies, councils or institutes. Of these, seven, five of these provinces have formal provincial legislation on quality improvement, including Alberta, Saskatchewan, Ontario, New Brunswick and Quebec:

- Health Quality Council of Alberta Act, SA 2011, c. H-7.2 (Health Quality Council of Alberta)
- Health Quality Council Act, SS 2002, c. H-0.04 (Health Quality Council, Saskatchewan)
- Excellent Care for All Act, 2010, SO 2010, c. 14 (Ontario Health Quality Council)
- New Brunswick Health Council Act, SNB 2008, c. N-5.105 (New Brunswick Health Council)
- An Act Respecting the Health and Welfare Commissioner, RSQ, c. C-32.1.1 (Quebec Health and Welfare Commissioner)

There is no specific legislation outlining the authorities of the BC Patient Safety & Quality Council or the Manitoba Institute for Patient Safety. For the Atlantic provinces, the Atlantic Health Quality and Patient Safety Collaborative (AHQPSC) consists of membership from the four Atlantic provinces: Newfoundland and Labrador, Prince Edward Island, New Brunswick, and Nova Scotia, and reports to the four Atlantic Deputy Ministers of Health. Thus, on this basis, all ten Canadian provinces appear to have an active patient safety and/or quality improvement agenda. In the territories, the Northwest Territories is actively addressing the priorities for their patient safety and accountability frameworks.

Each quality council or agency has specific priorities and activities for improving healthcare. For example in New Brunswick, Manitoba, and Saskatchewan, LEAN is the quality improvement methodology of choice for a number of provincial initiatives. It is noted that since 2012, the Health Quality Council of Alberta has a unique position to conduct public inquiries when authorized by the Lieutenant Governor in Council. In Ontario, the Excellent Care for All Act re-focuses healthcare on the quality of services provided and the creates public transparency in hospital level reporting of quality improvement plans and associated targets.

There are similarities regarding the roles and mandates of the various bodies, as well as some key differences. The following are some key similarities and differences regarding the roles and mandates according to a recent review of Alberta, Saskatchewan, Ontario, New Brunswick and Quebec legislation:

- Appointments are made by the Lieutenant Governor in Council (Alberta, Saskatchewan, Ontario and New Brunswick) or by the Government (Quebec).
- Most of the jurisdictions are permitted to further investigate healthcare quality issues at the request of the Minister (Alberta, Saskatchewan, New Brunswick, and Quebec). However, Alberta is the only jurisdiction that is able to conduct an investigation for patient safety and health services quality issues that are referred by a health authority.
- Alberta is the only province that is required to network with related organizations for the purposes of: sharing information on patient safety and health service quality issues; identifying and assessing

patient safety and health service quality issues; and developing and recommending effective practices in patient safety and health service quality.

- The mandate of some existing provincial quality/patient safety bodies is broader than patient safety and /or health service quality. For example, one of the functions of the Health Quality Ontario is to monitor and report to the people of Ontario on: access to publicly funded health services, health human resources in publicly funded health services, consumer and population health status, and health system outcomes.
- Three provincial bodies are required to monitor, evaluate, and report on health system performance: Saskatchewan's Health Quality Council, Health Quality Council of Alberta, and Health Quality Ontario.
- All five provincial bodies with a legislative foundation have a mandate to prepare reports and inform the public. As well, all bodies are required to submit annual reports that are tabled with the Legislative Assembly (Alberta, Saskatchewan, Ontario and New Brunswick) or the National Assembly (Quebec).
- The Health Quality Council of Alberta, and the Quebec Health and Welfare Commissioner are able to hold public inquiries which may involve comprehensive event analysis.

Three provinces (Saskatchewan, Manitoba and Quebec) have legislation that requires the reporting of various types of incidents that occur in health care facilities (hospitals, long-term care, child care, personal care homes) to the provincial Ministry of Health. Manitoba's provincial mandatory reporting legislation is beyond facilities. It pertains to regional health authorities which includes community health. It also pertains to provincial corporations as defined by the legislation. Today, all hospitals in Canada are required to report *C. difficile* infections to the Public Health Agency of Canada, though not every province makes the data publicly available.<sup>55</sup>

In addition to the quality agenda described above, patient safety and quality indicators are publicly reported on provincial government websites in Alberta, Ontario, BC, Nova Scotia, and Saskatchewan.

**Table 1. Summary Table of Patient Safety and Quality Legislation (as of March 2015)**

<b>Jurisdiction</b>	<b>QA Protection</b>	<b>Mandatory Disclosure</b>	<b>Mandatory Reporting</b>	<b>Apology Protection</b>
<b>BC</b>	<i>Evidence Act</i> , R.S.B.C. 1996, c.124, s. 51  Designation Regulation, BC Regulation 363/95	--	--	<i>Apology Act</i> , S.B.C. 2006, c. 19, s. 2
<b>AB</b>	<i>Alberta Evidence Act</i> , R.S.A. 2000, c. A-18, s. 9  Quality Assurance Committee Regulation, Alta. Reg. 294/2003  <i>Health Information Act</i> , R.S.A. 2000, c. H-5, ss. 35(1)(g), 35(2)-(3)  <i>Health Quality Council of Alberta Act</i> , S.A. 2011, c. H-7.2, s. 6	--	--	<i>Alberta Evidence Act</i> , R.S.A. 2000, c. A-18, s. 26.1
<b>SK</b>	<i>Evidence Act</i> , S.S. 2006, c. E-11.2, s. 10  <i>Regional Health Services Act</i> , S.S. 2002, c. R-8.2, s. 58(6)-(8)  <i>Health Information Protection Act</i> , S.S. 1999, c. H-0.021, ss. 27(4)(g), 38(1)(d)	Personal Care Homes Regulations, 1996, R.R.S. c. P-6.01 Reg. 2, s. 13	<i>Regional Health Services Act</i> , S.S. 2002, c. R-8.2, s. 58  Critical Incident Regulations, R.R.S. c. R-8.2 Reg. 3  Personal Care Homes Regulations, 1996, R.R.S. c. P-6.01 Reg. 2, s. 13	<i>Evidence Act</i> , S.S. 2006, c. E-11.2, s. 23.1
<b>MB</b>	<i>Manitoba Evidence Act</i> , C.C.S.M. c. 150, ss. 9-10  Medical Research Committees Regulation, Man. Reg. 461/88  <i>Personal Health Information Act</i> , C.C.S.M. c. P33.5, ss. 11(1)(d), 22(2)(e)	<i>Regional Health Authorities Act</i> , C.C.S.M. c. R34, 53.2(2)-(3)	<i>Regional Health Authorities Act</i> , C.C.S.M. c. R34, Part 4.1  Critical Incidents Regulation, Man. Reg. 211/2006	<i>Apology Act</i> , C.C.S.M. c.A98, s. 2
<b>ON</b>	<i>Quality of Care Information Protection Act</i> , 2004, S.O. 2004, c. 3, Sch. B  General, O. Reg. 330/04  Definition of Quality of Care Committee, O. Reg. 297/04	<i>Excellent Care for All Act</i> , 2010, S.O. 2010, c. 14, s. 8(2)  Hospital Management Regulation ( <i>Public Hospitals Act</i> ), R.R.O. 1990, Reg. 965, s. 2(4) – (6)	<i>Excellent Care for All Act</i> , 2010, S.O. 2010, c. 14, s. 8(2)  Hospital Management Regulation ( <i>Public Hospitals Act</i> ), R.R.O. 1990, Reg. 965, s. 2(4) – (6)	<i>Apology Act</i> , 2009, S.O. 2009, c.3

Jurisdiction	QA Protection	Mandatory Disclosure	Mandatory Reporting	Apology Protection
	Hospital Management Regulation ( <i>Public Hospitals Act</i> ), R.R.O. 1990, Reg. 965, s. 2(6)  <i>Personal Health Information Protection Act, 2004</i> , S.O. 2004, c. 3, Sch. A, ss. 7(4), 51(1)(a), 68(4)	O. Reg. 79/10, ( <i>Long-Term Care Homes Act, 2007</i> ) s. 135	O. Reg. 79/10, ( <i>Long-Term Care Homes Act, 2007</i> ) s. 135	
PQ	<i>An Act respecting Health Services and Social Services</i> , R.S.Q. c. S-4.2, ss. 183.1, 183.3, 183.4, 190, 213, 214, 218	<i>An Act respecting Health Services and Social Services</i> , R.S.Q. c. S-4.2, ss. 8, 235.1	<i>An Act respecting Health Services and Social Services</i> , R.S.Q. c. S-4.2, s. 233.1	--
NB	<i>Evidence Act</i> , R.S.N.B. 1973, c. E-11, s. 43.3  <i>Personal Health Information Privacy and Access Act</i> , S.N.B. 2009, c. P-7.05, ss. 14(1)(d), 40	--	--	--
NS	<i>Evidence Act</i> , R.S.N.S. 1989, c. 154, ss. 60-61	--	--	<i>Apology Act</i> , S.N.S. 2008, c. 34, s. 3
PEI	<i>Health Services Act</i> , R.S.P.E.I. 1988, c. H-1.6, ss. 26-31  <i>Medical Act</i> , R.S.P.E.I. 1988, c. M-5, s. 38.7	--	--	<i>Health Services Act</i> , R.S.P.E.I. 1988, c. H-1.6, ss. 26, 32
NL	<i>Evidence Act</i> , R.S.N.L. 1990, c. E-16, s. 8.1  <i>Personal Health Information Act</i> , S.N.L. 2008, c. P-7.01, ss. 41, 58	--	--	<i>Apology Act</i> , S.N.L. 2009, c. A-10.1
YT	<i>Evidence Act</i> , R.S.Y. 2002, c. 78, ss. 13, 13.1	--	--	--
NWT	<i>Evidence Act</i> , R.S.N.W.T. 1988, c. E-8, ss. 13-15	--	--	<i>Apology Act</i> , S.N.W.T. 2013, c. 14
NT	<i>Evidence Act</i> , R.S.N.W.T. (Nu) 1988, c. E-8, ss. 13-15	--	--	<i>Legal Treatment of Apologies Act</i> , S Nu. 2010, c. 12

In 2014, the Ontario Minister of Health and Long-Term Care convened a *Quality of Care Information Protection Act (QCIPA) Review Committee*, who submitted their report on December 23, 2014. On July 1, 2015 the Minister announced that he would implement all 12 of the Review Committee's recommendations related to QCIPA, the *Public Hospitals Act (PHA)* and critical incidents more broadly.

In September 2015 Ontario's Minister of Health and Long-Term Care (Ontario), introduced Bill 119, the *Health Information Protection Act, 2015 (HIPA)*. HIPA proposes to amend a number of statutes including major amendments to the *Personal Health Information Protection Act (PHIPA)* and QCIPA. HIPA proposes to repeal and replace the current QCIPA with a substantially revised QCIPA (2015). While the majority of the provisions in the current legislation would be retained in the new legislation, there are many new parameters set regarding the scope of QCIPA (2015) and the permitted disclosures under QCIPA (2015).

In conjunction with the changes to QCIPA proposed in Bill 119, the government has proposed amendments to Regulation 965 under the PHA regarding critical incident review and disclosure.

The proposed amendments to Regulation 965 would require that hospitals<sup>56</sup>:

- Establish a system for ensuring that a committee appointed by the hospital reviews every critical incident, as soon as is practicable after the critical incident occurs.
- Interview patients and their authorized representatives about the critical incident;
- Inform them of its causes where possible, in addition to already existing disclosure requirements; and
- Include a staff person responsible for patient relations in the committee conducting the review (including where a committee under QCIPA is used to conduct the review).

On September 1, 2015 Ontario passed Regulations 187/15 and 188/15 of the Excellent Care for All Act (ECFAA). ECFAA already included requirements regarding factors that must be considered in the development of the Quality Improvement Plan (QIP). Regulation 187/15 added the following requirements:

1. Each health care organization to engage patients and their caregivers in the development of its annual QIP; and
2. Every health care organization's annual QIP contains a description of the organization's patient engagement activities and an explanation of how these activities inform the development of the QIP.

Under section 6 of ECFAA, hospitals were already required to have patient relations processes in place and must make information on these processes available to the public. Regulation 188/15 added further requirements for those processes including specifying minimum standards respecting retention of certain information on complaints, keeping the patients or complainants informed, and ensuring a hospital has a specific patient relations process delegate.

Table 2 outlines the legislative mandate (objectives, activities, reporting to public and reporting/advice to Minister) of provincial health quality counsels for Alberta, Saskatchewan, Ontario, New Brunswick and Quebec.

**Table 2. Legislative Mandate of Provincial Health Quality Councils (as of October 30, 2015)**

	<b>AB – Health Quality Council of Alberta</b>	<b>SK – Health Quality Council</b>	<b>ON – Ontario Health Quality Council*</b>	<b>NB – New Brunswick Health Council</b>	<b>QC – Health and Welfare Commissioner</b>
Appointment of Council Members / Health and Welfare Commissioner	Appointments are made by the Lieutenant Governor in Council: s. 4(1)	Appointments are made by the Lieutenant Governor in Council: s. 4(1)	Appointments are made by the Lieutenant Governor in Council: s. 10(2)	Appointments are made by the Lieutenant Governor in Council: s. 2	The Government appoints the Health and Welfare Commissioner: s. 1
Objects of Council / Commissioner	The objects of the Council are to promote and improve patient safety and health service quality on a province-wide basis: s. 3(1)	5 The objects of the council are: (a) to monitor existing clinical standards of health care and to research and develop new clinical standards of health care; (b) to research and evaluate prescription drug prescribing practices, prescription drug utilization and existing processes for reviewing and approving prescription drugs; (c) to assess the effectiveness of new and existing health technologies; (d) to promote improvement in the quality of health care through training and education; (e) to develop and implement training and education programs and activities to promote improvement in the quality of health care; (f) to promote research and education leading to improvement in the quality of health care; (g) to monitor and assess the quality of the health services	12. (1) The functions of the Council are*, (a) to monitor and report to the people of Ontario on, (i) access to publicly funded health services, (ii) health human resources in publicly funded health services, (iii) consumer and population health status, and (iv) health system outcomes; (b) to support continuous quality improvement; (c) to promote health care that is supported by the best available scientific evidence by, (i) making recommendations to health care organizations and other entities on standards of care in the health system, based on or respecting clinical practice guidelines and protocols, and (ii) making recommendations, based on evidence and with consideration of the recommendations in subclause (i), to the Minister concerning the Government of Ontario's provision of funding	3 The objects and purposes of the Council are as follows: (a) to promote the improvement of health service quality in the Province; (b) to develop and implement mechanisms to engage the citizens of New Brunswick in meaningful dialogue for the purpose of improving health service quality in the Province; (c) to measure, monitor and assess population health and health service quality in the Province; (d) to identify effective practices for the improvement of health service quality in the Province; (e) to evaluate strategies designed to improve health service quality in the Province; (f) to assess citizen satisfaction with health services and health service quality in the Province; (g) to investigate matters respecting the health care system that are referred to it by the Minister; (h) to provide recommendations to the	2. With a view to improving the health and welfare of the population, the Commissioner is responsible for assessing the results achieved by the health and social services system taking into account the range of systemic factors that interplay within the system, and for providing the public with the necessary background for a general understanding of the actions undertaken by the Government to address the major issues in the health and social services arena.  The Commissioner exercises these responsibilities with regard to such matters as the quality, accessibility, integration, insurability and funding of services, the determinants of health and welfare, the ethical aspects of health and welfare, medications and technology.  8. The Commissioner appoints one or more Deputy Commissioners from among

	AB – Health Quality Council of Alberta	SK – Health Quality Council	ON – Ontario Health Quality Council*	NB – New Brunswick Health Council	QC – Health and Welfare Commissioner
		<p>available in Saskatchewan;</p> <p>(h) to investigate, inquire into or study matters respecting health services and the quality of health care that are referred to it by the minister;</p> <p>(i) to undertake research with respect to any of the objects described in clauses (c) to (h);</p> <p>(j) to identify human resource issues associated with the objects described in clauses (a) to (h);</p> <p>(k) to do any other things prescribed in the regulations;</p> <p>(l) to make recommendations to the minister and others with respect to any of the objects described in clauses (a) to (k).</p>	<p>for health care services and medical devices;</p> <p>(d) any other functions provided for in the regulations.</p> <p>(2) In making recommendations under clause (1) (c), the Council shall take into account implications for health system resources.</p>	<p>Minister with respect to any of the activities described in paragraphs (a) to (g);</p> <p>(h.1) to take into account the particular needs of the two official linguistic communities in the exercise of the activities referred to in paragraphs (a) to (h); and</p> <p>(i) to carry out such other activities or duties as may be authorized or required by this Act or as the Lieutenant-Governor in Council may direct.</p>	<p>the Commissioner's personnel. One of the Deputy Commissioners must be specifically responsible for the ethical aspects of health and welfare</p>
Activities of Council / Commissioner	<p>3(2) The Council shall undertake the following activities in co-operation with health authorities:</p> <p>(a) measure, monitor and assess patient safety and health service quality;</p> <p>(b) identify effective practices and make recommendations for the improvement of patient safety and health service quality;</p> <p>(c) assist in the</p>	See above objects.	See above objects.	See above objects.	<p>14. To fully exercise the responsibilities of office, the Health and Welfare Commissioner, among other functions,</p> <p>(1) evaluates all components of the health and social services system to determine their relevance;</p> <p>(2) periodically assesses the results achieved by the health and social services system in</p>



	AB – Health Quality Council of Alberta	SK – Health Quality Council	ON – Ontario Health Quality Council*	NB – New Brunswick Health Council	QC – Health and Welfare Commissioner
	<p>implementation and evaluation of activities, strategies and mechanisms designed to improve patient safety and health service quality;</p> <p>(d) survey Albertans on their experience and satisfaction with patient safety and health service quality;</p> <p>(e) other activities as provided for in the regulations.</p>				<p>light of the resources allocated to it and of reasonable expectations given these resources;</p> <p>(3) informs the Minister and the public of the overall performance of the health and social services system, the changes proposed by the Commissioner to improve such aspects of the system as its effectiveness and efficiency, and the issues and implications associated with the proposed changes;</p> <p>(4) releases information to enable public debate on and a general understanding of the issues to be addressed and the choices to be made to ensure the sustainability of the health and social services system; and</p> <p>(5) submits advisory opinions to the Minister on the state of health and welfare of the population in light particularly of retrospective analysis of the impact of government policy on that state.</p>
Referral by Minister	On the request of the Minister, the Council shall assess or study matters respecting patient safety	One of the objects of the council is to investigate, inquire into or study matters respecting health services and	No specific provision.	One of the objects of the council is to investigate matters respecting the health care system that are referred	15. The Government or the Minister may entrust the Commissioner with any special mandate on a matter

	<b>AB – Health Quality Council of Alberta</b>	<b>SK – Health Quality Council</b>	<b>ON – Ontario Health Quality Council*</b>	<b>NB – New Brunswick Health Council</b>	<b>QC – Health and Welfare Commissioner</b>
	and health service quality that are referred to it by the Minister: s. 15(1)	the quality of health care that are referred to it by the minister: s. 5(h)		to it by the Minister: 3(g)	within the Commissioner's competence.
Referral by Health Services Provider	15(2) The Council may assess or study matters respecting patient safety and health service quality that are referred to it by a health authority.	No specific provision.	No specific provision.	No specific provision.	No specific provision.
Requirement to Network with other Organizations	13 The Council shall network with health professions, health authorities, organizations providing health services, academic health centres and other related organizations for the purposes of (a) sharing information on patient safety and health service quality issues, (b) identifying and assessing patient safety and health service quality issues, and (c) developing and recommending effective practices in patient safety and health service quality.	No specific requirement.	No specific requirement.	No specific requirement.	No specific requirement.
Report to Public	The Council must report to Albertans on any survey it conducts in relation to their experience and satisfaction with patient safety and health service quality: s. 14(a)	The council shall regularly prepare and publish reports on the activities of the council, the research promoted or undertaken by the council and the recommendations made by the council: s. 21.	12. (1) The functions of the Council are, (a) to monitor and report to the people of Ontario on, (i) access to publicly funded health services, (ii) health human resources in publicly funded health	6 The Council shall prepare and publish from time to time reports containing, but not limited to, information in relation to the following: (a) activities of the Council; (b) population health and health service quality;	14. To fully exercise the responsibilities of office, the Health and Welfare Commissioner, among other functions,  (3) informs the Minister and the public of the overall

	AB – Health Quality Council of Alberta	SK – Health Quality Council	ON – Ontario Health Quality Council*	NB – New Brunswick Health Council	QC – Health and Welfare Commissioner
			services, (iii) consumer and population health status, and (iv) health system outcomes;	(c) research promoted or undertaken by the Council; (d) recommendations related to the improvement of health service quality made by the Council; and (e) any other matter that relates to the Council’s objects and purposes under section 3.	performance of the health and social services system, the changes proposed by the Commissioner to improve such aspects of the system as its effectiveness and efficiency, and the issues and implications associated with the proposed changes;  (4) releases information to enable public debate on and a general understanding of the issues to be addressed and the choices to be made to ensure the sustainability of the health and social services system;
Advice to the Minister	14 The Council shall advise the Minister on (i) the quality of health services in the health care system, (ii) results and recommendations of the work of the Council on patient safety and health service quality, and (iii) other matters as requested by the Minister,	One of the objects of the Council is to make recommendations to the Minister and others with respect to any of the other objects: s. 5(l).	One of the functions of the Council is to promote health care that is supported by the best available scientific evidence by making recommendations “to the Minister concerning the Government of Ontario’s provision of funding for health care services and medical devices” s. 12(1)(c)(ii)	One of the objects of Council is to provide recommendations to the Minister with respect to any of the activities described in paragraphs 3(a) to (g) (see above “objects of council”): 3(h)	14. To fully exercise the responsibilities of office, the Health and Welfare Commissioner, among other functions,  (5) submits advisory opinions to the Minister on the state of health and welfare of the population in light particularly of retrospective analysis of the impact of government policy on that state.
Report to the Minister	Yes, reporting is required. The Council shall at the request of the Minister, prepare and submit to the Minister any reports	Yes, reporting is required. The council submits an annual report to the Minister. The report must contain (a) a report to the Minister on	Yes, reporting is required. 13. (1) The Council shall deliver to the Minister, (a) a yearly report, (i) on the state of the health	Yes, reporting is required. 22(1) The Council shall submit a report annually to the Minister containing the following information:	Yes, reporting is required. 22. Not later than 31 October each year, the Commissioner sends the Minister a report on the exercise of the function

	AB – Health Quality Council of Alberta	SK – Health Quality Council	ON – Ontario Health Quality Council*	NB – New Brunswick Health Council	QC – Health and Welfare Commissioner
	<p>respecting the activities of the Council that the Minister requires: s. 14(c) As well, the Council is required to submit an annual report to the Speaker of the Legislative Assembly. The Speaker must lay the report before the Legislative Assembly: s. 24.</p>	<p>the activities of the council for the preceding fiscal year; and (b) a financial statement showing the business of the council for the preceding fiscal year in any form that may be required by Treasury Board. The Minister tables the annual report with the Legislative Assembly: s. 19(1). In addition, at any times required by the minister, the board shall prepare and submit to the Minister any reports respecting the activities of the council that the Minister may require: s. 20.</p>	<p>system in Ontario, and (ii) respecting its recommendations under clause 12 (1) (c); and (b) any other reports required by the Minister. (2) The Minister shall table every yearly report under this section in the Legislative Assembly within 30 days of receiving it from the Council, but is not required to table the Council's annual business plan. (3) The purpose of reporting under subclause (1) (a) (i) is to, (a) encourage and promote an integrated, consumer centred health system; (b) make the Ontario health system more transparent and accountable; (c) track long-term progress in meeting Ontario's health goals and commitments; and (d) help Ontarians to better understand their health system. 2010, c. 14, s. 13 (3). (4) The purpose of reporting under subclause (1) (a) (ii) is to, (a) summarize the recommendations made under clause 12 (1) (c); (b) promote the use of the best available scientific evidence in the provision of</p>	<p>(a) a report on the activities of the Council for the preceding fiscal year; (b) a summary of the audited financial statements submitted under section 21; and (c) such other information as the Minister may require. 22(2) The Council shall submit the annual report to the Minister no later than the thirty-first day of July in each year for the preceding fiscal year. 22(3) The Minister shall lay the annual report before the Legislative Assembly if it is in session or, if not, at the next ensuing session. 23 The Council shall prepare and submit to the Minister such reports, records, documents or other information that the Minister may require from time to time, within the time and in the form specified by the Minister.</p>	<p>assigned to the Commissioner under paragraph 3 of section 14 (see above activities of Commissioner)</p> <p>The Minister lays the report before the National Assembly within 30 days of its receipt or, if the Assembly is not sitting, within 30 days of resumption. The report is referred to the appropriate committee of the National Assembly for consideration.</p> <p>23. As soon as the Commissioner is ready to submit findings or an advisory opinion on a matter that falls within the Commissioner's purview, the Commissioner may send a special report to the Minister or choose to include the findings or advisory opinion in the report referred to in section 22.</p> <p>The Minister lays a special report before the National Assembly within 30 days of its receipt or, if the Assembly is not sitting, within 30 days of resumption.</p> <p>36. Not later than 30 June each year, the Commissioner sends the Minister a report on the Commissioner's activities</p>

	AB – Health Quality Council of Alberta	SK – Health Quality Council	ON – Ontario Health Quality Council*	NB – New Brunswick Health Council	QC – Health and Welfare Commissioner
			health care in Ontario; (c) measure the impact of the use of the best available evidence on health care in Ontario; (d) identify areas where the use of the best available scientific evidence could improve health care provision in Ontario; and (e) publicize and make transparent the process by which decisions are made about funding health care services and medical devices in Ontario.		for the preceding fiscal year.  The Minister lays the report before the National Assembly within 30 days of its receipt or, if the Assembly is not sitting, within 30 days of resumption.  45. Not later than 1 June 2013, the Commissioner reports to the Minister on the implementation of this Act.  The Minister lays the report before the National Assembly within 30 days of its receipt or, if the Assembly is not sitting, within 30 days of resumption. The report is referred to the appropriate committee of the National Assembly for consideration.
Authority to establish a Public Inquiry	Yes. The Lieutenant Governor in Council must direct the council to establish a public inquiry. The nature and scope of the inquiry is directed by the LG in C, including the date for submission of the report and recommendations: s. 17(1).	No	No	No	Yes. The Commissioner may hold an inquiry if expedient for the exercise of the functions of office: s. 21

\*Amendments to Ontario's *Excellent Care for All Act* received Royal Assent in 2014. These amendments are awaiting proclamation and are not yet in force. They will be included in the chart when they come into force.

## Canadian Literature

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The following section reviews recent literature on patient safety and quality in Canada. Interestingly, the findings are mainly focused on the need for strong leadership, patient/family involvement, and measurement which are the main themes from *Forward with Patient Safety: Commitment through Action*.

There are a number of patient safety and quality initiatives at the provincial and national level across Canada. In its 2013 report entitled “Which Way to Quality?” the Health Council of Canada highlighted several key provincial initiatives.<sup>57</sup> The report clearly identifies that compared to other high income countries, Canada ranks in the middle or bottom of the list for the quality of our health system.

The authors interviewed health system leaders with respect to their experience with quality improvement efforts. A survey of federal/provincial/territorial ministries of health was also completed. The report states that key factors for system wide quality improvement are:

- leadership
- measurement, targets, and accountability
- capacity building (education, training, and facilitation)
- evidence informed care
- patient and family engagement

The report concludes with “The Health Council believes that it is time for Canada’s senior leaders to come to establish common and measurable goals for quality improvement” (p. 35).

The Health Council of Canada also released a 2013 report (Better health, better care, better value for all) looking at the impact of healthcare reform in Canada<sup>58</sup> since the 2003 First Ministers’ Accord on Healthcare Renewal and the 2004 10-Year Plan to Strengthen Healthcare. The report reviews the priorities of this agenda, including quality, accessibility, and sustainability.

The Council found that the last 10 years saw few improvements on measures of patient care and health outcomes, and Canada’s performance compared to other high-income countries is disappointing. Some pressing issues have been addressed including wait times, primary healthcare reform, drug coverage, and physicians’ use of electronic health records. But none of these changes have transformed Canada’s health system into a high-performing one, and health disparities and inequities continue to persist across the country.

Furthermore, the health system has not kept pace with the evolving needs of Canadians, failing to address the growing need for better prevention and management of chronic disease, improved primary care, and expanded home care services to meet the needs of the aging society.

Other key findings are:

- A call for strong pan-Canadian leadership if meaningful transformation of our health system is to occur.
- Similar to other nations, support for the use of IHI’s Triple Aim framework as a starting point for pursuing a higher-performing health system in Canada, with a balanced focus on achieving the complementary goals of better health, better care, and better value as well as equity being addressed along with these three aims.
- A broader and balanced transformation of the health system is required—one guided by a shared

vision for a high-performing health system, explicit system goals, and a sustained focus on supporting key enablers.

- Federal government should play a central role in providing funding to ensure a level of equity across Canada and continue to represent the fundamental “Canadian” perspective through active participation in health system planning and policy development. Provinces and territories must look beyond their jurisdictional responsibilities and recognize that they are co-owners of a national system. They have a shared responsibility to ensure that each jurisdiction delivers comparable results.

Five key enablers are offered to realize the goal of a high performing system:

- 1) leadership;
- 2) policies and legislation;
- 3) capacity building;
- 4) innovation and spread; and
- 5) measurement and reporting.

The report makes the following bold statement: “The outcomes have been modest and Canada’s overall performance is lagging behind that of many other high-income countries. The status quo is not working. We need to do the business of health reform differently” (page 3).

Another recent study, funded by the Canadian Institutes for Health Research, explored the question “What is required to sustain transformation of organizational cultures within systems?”<sup>59</sup> This research was conducted by University of British Columbia researchers, and was informed by eight international experts through an Expert Advisory Panel and a core group of advisors from the Saskatchewan Ministry of Health. The intent of this work is to assist the province of Saskatchewan in its transformation of the health system and to consider the factors that will sustain cultural transformation. This research offers insights into the factors that may need to be considered for sustaining transformative change.

The authors state that contextual factors and mechanisms that contribute to successful transformation of large health systems, such as:

- 1) Blend designated leadership with distributed leadership
- 2) Establish feedback loops (through collection and timely analysis of data)
- 3) Attend to history
- 4) Engage physicians; and
- 5) Include patients and families

In addition, existing contextual factors influencing sustainability of culture change include:

- Values –The more a change initiative can be framed as consistent with organizational values pre-change, the less resistance it is likely to produce, and the more likely it is to be sustained.
- External context – The political goals or mandates, economic reality, or actions of other organizations can all influence how sustainable culture change can be. The more supportive the external context of the intended change, the more likely it is to be sustained.

- Internal Resources – The more financial and human resources (including staffing, skills, professional training, etc.) support the desired culture change; the more likely it is to be sustained.
- Leadership Commitment – The more committed top leadership is to the change in question, the more likely it is that the change will be sustained.
- Continuity of Leadership – Loss of continuity of leadership has been identified as one of the main threats to sustainability. Without continuous support by leadership, culture change is less likely to be sustained.

Several mechanisms have also been shown to facilitate sustainability of organizational culture change. The researchers offer the following six mechanisms based on their review of the literature:

- 1) Align vision with action – Alignment of organization goals with resource allocation and actions at all levels of the organization will interact with the contextual factors identified above in ways that support the sustainability of culture change.
- 2) Apply distributed leadership – Distributed leadership is a collective enterprise with a variety of actors sharing in change agency roles. Staff in positions not normally identified as leadership roles can effectively drive change.
- 3) Engage staff in problem solving – Engagement at all levels generates a perception of ownership of the change, which counteracts a key barrier to the sustainability of change.
- 4) Establish relationships – The existence of good relationships within an organization can serve to socially reinforce changes in culture and practice. Interpersonal relationships can also enable a change manager to build trust and neutralize resistance to change.
- 5) Measure/demonstrate links between change and performance – Measurement of culture itself, when incorporated into a process for measuring and reporting back results, can help sustain culture change.
- 6) Make change incrementally – Successful change is supported by simplicity of the change, degree that it is similar to previous practices, and that it is rolled out in stages or small steps.



## Conclusion

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Patient safety and quality initiatives are actively being implemented throughout Canada. In addition, the commitment to improve healthcare quality is evident in many strategic plans. Several provinces are willing to align measurement and reporting of indicators that support benchmarking. Herein lays an opportunity for a national, integrated action plan for patient safety. Recent publications state that now is the time for unprecedented level of collaboration and action.

The requisite for strong pan-Canadian leadership is recognized as essential for meaningful transformation of our health system. The report by the Health Council of Canada concludes with “The Health Council believes that it is time for Canada’s senior leaders to come to establish common and measurable goals for quality improvement” (p. 35). The Integrated Patient Safety Action Plan has the potential to advance unprecedented improvements in Canada. Provinces and territories, national organizations and provincial health quality councils are already looking beyond their jurisdictional responsibilities and with growing recognition that all the players are co-owners of a national system, where each jurisdiction delivers comparable quality and patient safety results for Canadians. Collectively there is amazing potential for consensus on the major components of an Integrated Patient Safety Action Plan, drawing on the best of each participant.



## Appendix A- Publicly Reported Indicators by Ontario

### Ontario Publicly Reported Patient Safety Indicators for Hospitals

<http://www.hqontario.ca/public-reporting/patient-safety/information-about-patient-safety-quality-indicators>

Patient Safety Indicator	Start Date of Public Reporting	Reporting Period	Numerator	Denominator	Risk Adjustment	Data Source
New hospital-associated <i>Clostridium difficile</i> (CDI) rate per 1,000 patient days	Sept. 30, 2008	Monthly	Number of new cases observed in hospital during the reporting period	Number of patient-days per reporting period	N/A	MOHLTC
New hospital-associated Methicillin Resistant <i>Staphylococcus aureus</i> (MRSA) bacteremia rate per 1,000 patient days	Dec. 31, 2008	Quarterly	Number of new cases observed in hospital during the reporting period	Number of patient-days per reporting period	N/A	MOHLTC
New hospital-associated Vancomycin Resistant <i>Enterococcus</i> (VRE) bacteremia rate per 1,000 patient days	Dec. 31, 2008	Quarterly	Number of new cases observed in hospital during the reporting period	Number of patient-days per reporting period	N/A	MOHLTC
Hospital Standardized Mortality Ratio (HSMR)	Dec. 31, 2008	Annually	Number of observed deaths	Number of expected deaths	Adjusted for several factors that affect in-hospital mortality, including age, sex, length of stay, admission category, diagnosis group, co-morbidity and transfer from another acute care institution.	CIHI
New Ventilator-Associated Pneumonia (VAP) rate per 1,000 ventilator days	April 30, 2009	Quarterly	Total number of newly diagnosed cases in ICU after at least 48	Number of ventilator days in that reporting period	N/A	MOHLTC

Patient Safety Indicator	Start Date of Public Reporting	Reporting Period	Numerator	Denominator	Risk Adjustment	Data Source
			hours of mechanical ventilation during the reporting period			
New Central Line Infections (CLI) rate per 1,000 central line days	April 30, 2009	Quarterly	Number of new cases in ICU after at least 48 hours of receiving a central line during the reporting period	Number of central line days in that reporting period	N/A	MOHLTC
Rates of Surgical Site Infection (SSI) Prevention (Hip and Knee replacement)	April 30, 2009	Quarterly	Number of hip/knee total joint replacement surgeries in which the patient received antibiotics within the appropriate time	Total number of patients during the reporting period who had a primary knee/hip total joint replacement surgical procedure	N/A	MOHLTC
Hand hygiene compliance before patient contact	April 30, 2009	Annually	Number of times hand hygiene performed before initial patient contact	Number of observed hand hygiene opportunities before initial patient contact	N/A	MOHLTC
Hand hygiene compliance after patient contact	April 30, 2009	Annually	Number of times hand hygiene performed after patient contact	Number of observed hand hygiene opportunities after patient contact	N/A	MOHLTC
Surgical Safety Checklist Compliance (SSCC)	July 30, 2010	Bi-annually	Number of times Surgical Safety Checklist was used	Total Surgeries	N/A	MOHLTC

## Ontario Publicly Reported Quality Indicators for Home Care

HQO publicly reports on 11 quality indicators for home care services at the provincial level and Community Care Access Centre (CCAC) level. One indicator, patient experience, is also reported at the service provider organization level.

Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
<b>Accessible</b>	Waiting for nursing services	Percentage of home care patients who received their first nursing visit within five days of the date they were authorized for nursing services	The number of home care patients who received their first nursing service visit within five days of the date they were authorized for nursing services by the Community Care Access Centre	The number of adult home care patients who received in-home nursing services, <sup>1</sup> excluding shift nursing	None	HCD
<b>Accessible</b>	Waiting for personal support services for complex patients	Percentage of home care patients with complex needs who received their first personal support visit within five days of the date they were authorized for personal support services	Numerator The number of complex home care patients who received their first personal support service visit within five days of the date they were authorized for support services by the Community Care Access Centre	Denominator The number of adult complex home care patients who received in-home personal support services	None	HCD
<b>Effective</b>	Incontinence	Percentage of home care clients who have newly developed bladder incontinence or	The number of home care patients who either 1) have developed a new bladder	The number of home care patients with at least one reassessment, excluding patients	Adjusted for difficulty with dressing, cognitive impairment,	HCRS

Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
		whose bladder functioning has not improved since their previous assessment	continence problem or 2) experienced a decline or did not improve in bladder continence between previous and most recent assessment	who do not have urine output from bladder	age, and whether the client is post-acute	
<b>Effective</b>	Communication	Percentage of home care patients with a new problem communicating or existing communication problem that did not improve since their previous assessment	The number of home care clients with new difficulties in making themselves understood or understanding others, or home care clients with both failure to improve in making themselves understood and failure to improve in understanding others	The number of home care clients with at least one reassessment	Adjusted for activities of daily living impairment and cognitive impairment	HCRS
<b>Effective</b>	Hospital readmissions	Percentage of home care patients with unplanned hospital readmissions within 30 days of referral from hospital to Community Care Access Centre after acute hospital discharge	The number of unplanned hospitalizations by home care patients newly referred to home care services within 30 days of initial hospital discharge	The number of unplanned hospitalizations by home care patients newly referred to home care services within 30 days of initial hospital discharge.	None	HCD, DAD, RPDB
<b>Safe</b>	Falls	Percentage of home care patients	The number of home care patients	The number of home care patients not	Adjusted for age, reduced	HCRS

Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
		who fell in the last 90 days	who fell in the last 90 days	totally dependent on bed mobility on assessment.	physical activity in the last three days, unsteady gait, diagnosis of arthritis and cognitive impairment	
<b>Safe</b>	Pressure ulcers	Percentage of home care clients with a new pressure ulcer (stage 2 to 4)	The number of home care clients with a new pressure ulcer (stage 2 to 4) on current assessment	The number of home care clients with at least one reassessment and had no/stage 1 pressure ulcers on previous assessment	Adjusted for activities of daily living impairment	HCRS
<b>Patient - Centred</b>	Patient satisfaction (provincial/CCAC)	Percentage of home care patients who were satisfied with their care from both care coordinators and service providers	The sum of the number of positive responses to the three questions described in the denominator. A positive response is a response of good, very good or excellent on a five-point scale.	The sum of the number of responses to three survey questions asking the home care patient, or their caregiver if they are unable to respond, to rate the following: Overall, the services received from the Community Care Access Centre and any individuals who provided care. The management and handling of their care by the care coordinator. Overall, the service provided by their	None	CCAC Client and Caregiver Experience Evaluation Survey

Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
				<p>service provider. This indicator includes survey responses from home care patients or their caregivers who were asked in the survey about any of the following services received: nursing personal support, physiotherapy, occupational therapy, nutrition/dietetics, speech language therapy, or social work.</p>		
<b>Patient - Centred</b>	Patient satisfaction (provider)	Percentage of home care patients who were satisfied with the services provided by their service provider	<p>The number of positive responses to the survey question asking the home care patient to rate the service provided by the service provider</p> <p>A positive response is a response of good, very good or excellent on a five-point scale</p>	<p>The number of responses to the survey question asking the home care patient, or their care giver if they are unable to respond, to rate the service provided by their service provider.</p> <p>This indicator includes survey responses from home care patients or their caregivers who were asked in the survey about nursing or personal</p>	None	



Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
				support services only.		
<b>Efficient</b>	Emergency department visits	Percentage of unplanned emergency department visits by home care clients within 30 days for referrals from hospital to CCAC after acute hospital discharge	The number of unplanned emergency department visits by home care patients newly referred to home care services within 30 days of initial hospital discharge	The number of home care applications from patients referred from hospital care service visit.	None	HCD, NACRS, RPDB
<b>Long-term care</b>	Long-term care	Percentage of home care patients placed in long-term care who could have stayed home or somewhere else in the community	The number of home care patients placed in long-term care with care needs less than high or very high. Care needs are based on the Method of Assigning Priority Levels (MAPLe) that takes into account several clinical variables. MAPLe differentiates patients into five priority levels based on their risk of adverse outcomes (low, mild, moderate, high, and very high). Patients in priority levels less than high or	The number of home care patients placed in long-term care, excluding patients who have moved from one long-term care home to another.	None	RAI-HC  CCAC data systems  CPRO

Attribute	Theme	Indicator	Numerator	Denominator	Risk Adjustment	Data Source
			very high may be appropriately cared for at home or somewhere else in the community other than a long-term care facility.			
<b>Focused on Population</b>	Vaccination	Percentage of home care clients who have not received influenza vaccination in the past two years	The number of home care clients who have not received influenza vaccination within the past two years	The number of home care clients, excluding clients receiving chemotherapy / radiation therapy	None	HCRS

## Ontario Publicly Reported Quality Indicators for Long Term Care

At the provincial level, HQO reports on 11 indicators related to the quality of our long-term care system: wait times, incontinence, activities of daily living, cognitive function, pain, falls, pressure ulcers, restraint use, medication safety, health human resources and infection rates. For individual long-term care homes, HQO reports on four indicators: falls, incontinence, pressure ulcers and restraint use. The technical details for these four indicators are reflected in this table.<sup>60</sup>

Attribute	Health topic	Indicator	Numerator	Denominator	Risk Adjustment – Individual Covariates	Risk Adjustment – Facility Level Stratification	Data Source
Effective	Incontinence	Percentage of residents with worsening bladder control	Residents with a greater value for bladder incontinence on their target compared with prior assessment	Residents with valid assessments whose bladder continence could worsen (did not have maximum score on prior assessment), excluding comatose and end-of-life residents	PSI Subset 1: Diagnoses; PSI Subset 2: Non-Diagnoses; CPS; RUG Nursing CMI; Age younger than 65	ADL Long Form	CIHI
Safe	Falls	Percentage of residents who had a recent fall	Residents who had a fall in the last 30 days recorded on their target assessment	Residents with valid assessments	Not totally dependent in transferring; Locomotion problem; PSI Subset 2: Non-Diagnoses; Any wandering; Unsteady gait/cognitive impairment; Age younger than 65	CMI	CIHI
Safe	Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently worsened	Residents who had a pressure ulcer at stages 2 to 4 on their target assessment and the stage of	Residents with valid assessments excluding those who had a stage 4 ulcer on their prior assessment	RUG Late Loss ADL; Age younger than 65	CMI	CIHI

Attribute	Health topic	Indicator	Numerator	Denominator	Risk Adjustment – Individual Covariates	Risk Adjustment – Facility Level Stratification	Data Source
			pressure ulcer is greater on their target compared with their prior assessment				
Safe	Restraints	Percent of residents who were physically restrained	Residents who were physically restrained daily on their target assessment	Residents with valid assessments, excluding comatose residents and those who are quadriplegic	None	ADL Long Form	CIHI

### Ontario Publicly Reported Quality Indicators in Primary Care

HQO launched the Ontario Primary Care Performance Measurement initiative in 2012, in collaboration with key stakeholders. Comprised of organizations representing patients, providers, data holders, researchers, managers and policymakers from across Ontario, the Primary Care Performance Measurement Steering Committee completed the first phase of its work with a report released September 2014, entitled A Primary Care Performance Measurement Framework for Ontario<sup>61</sup>.

The Primary Care Performance Measurement Framework (PCPM Framework) has nine domains that align with Health Quality Ontario’s nine attributes of a high-performing health care system (access, patient-centeredness, integration, effectiveness, focus on population health, efficiency, safety, appropriate resources and equity). Each domain has a set of measurement priorities and each measurement priority includes a set of recommended measures at the practice and system levels. The PCPM Framework includes 112 practice-level and 179 system-level measures. Ninety-two measures are common to both levels. The measures are categorized based on their province-wide availability as: currently reported; currently reported, but modified wording is recommended, and not currently available. Data is currently available for 15(13%) of the recommended practice-level measures and 73(41%) of the system-level measures. The PCPM Steering Committee will guide the implementation of the PCPM Framework. Primary care stakeholders will share the responsibility for implementing the performance measures. In the near term, the Steering Committee will recommend a subset of measures and approaches for data collection to support immediate measurement. The Steering Committee has provided a list of recommendations and next steps, which are described in the full report.

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