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2015-16: By the Numbers

- 252,534 website visits to the new Canadian Patient Safety Institute website
- 97,976 social media interactions (likes, shares, comments, replies, video views and other interactions)
- 38 per cent increase in social media interactions on Twitter, LinkedIn, YouTube, Facebook and other platforms
- 33,324 YouTube views totalling an estimated 106,630 minutes of viewing time
- 29 campaigns promoted with 667,107 emails sent
- 24 presentations and keynote addresses at provincial and national conferences
- 92 actions identified for the Integrated Patient Safety Action Plan; 45 Actions underway and 19 complete as of March 31st
- 70 volunteer patient members of Patients for Patient Safety Canada (PFPSC)
- 15 PFPSC members achieved the WHO Patient Safety Champion designation; 37 members hold this unique designation
- 12,000 views of Global Patient Safety Alert summaries; users from more than 100 countries around the world
- 1,200 alerts and 6,100 recommendations from 26 contributing organizations worldwide in Global Patient Safety Alerts
- 1,286 organizations enrolled in Patient Safety Metrics; 538 organizations actively submitting data
- 152 acute care, long-term care and home care participants in Falls Audit with 3,499 charts audited
- 52 sites participated in the Surgical Site Infection Audit with 1,998 patient charts audited
- 8 national improvement webinars with 865 participants
- 44 teams participated in a national Pain, Agitation and Delirium Collaborative in Critical Care
- 5 teams participated in Home Care Safety Falls Prevention Virtual Improvement Collaborative
- 107 new patient safety trainers certified at four Patient Safety Education Program – Canada conferences; 31 organizations across the country participated
- 40 participants attended the Advancing Safety for Patients in Residency Education (ASPIRE) french educational session
- 41 participants attended the Canadian Patient Safety Officer Course
- 185 attendees at the Atlantic Learning Exchange
- 122 Effective Governance for Quality and Patient Safety (EGQPS) program participants
- 90 per cent of EGQPS participants reported an increase in knowledge as a result of participating in the program and would recommend this session to a colleague
- 29,476 page views and 474 PDF downloads of the Patient Safety and Incident Management Toolkit
- 1,178 Canadian Patient Safety Week registrants; 600 promotional packages purchased
- 150,000 copies of Hands in Healthcare magazine distributed
- 1,100 viewers from over 600 sites in Canada and six other countries at Canada’s Forum on Patient Safety and Quality Improvement; 46 speakers featured during 15 hours of programming
In the past year, the Canadian Patient Safety Institute experienced an increased demand for our products and services and continuously sought new opportunities to expand, improve, and develop new partnerships to meet the needs of the Canadian healthcare system.

The Board is proud of the many significant outcomes achieved over the past year, including, but not limited to, the release of the following sentinel tools and reports: Never Events for Hospital Care in Canada, Five Questions to Ask About Your Medications, and Surgical Safety in Canada: A 10-year review of CMPA and HIROC medico-legal data.

I am excited about the Canadian Patient Safety Institute’s continued commitment to healthcare research, and the new conversations generated as a result. Highlights this year include four studentship awards engaging master’s and PhD students to support actions of the Integrated Patient Safety Action Plan, and 12,000 views of specific Global Patient Safety Alerts summaries from users in over 100 countries around the world. Global Patient Safety Alerts is a growing repository of 1,200 alerts and 6,100 recommendations from 26 contributing organizations worldwide.

As we reflect on this past year, and also look forward, we are encouraged that patient safety continues to be a priority for the Canadian Government as they look to better integrate all parts of the healthcare system and deliver quality care, closer to home. As an accountable steward of resources, we ensure the most efficient and effective use of all funding in the best interests of patients, caregivers, and the public.

We invite you to read through our Annual Report that highlights our commitment to patient safety told through the stories of our patients and caregivers, accompanied by key facts and figures that demonstrate our unwavering commitment to quality and accountability at all levels.

Susan Mumme
This year has been marked by amazing progress on a number of fronts. The Canadian Patient Safety Institute is on the forefront of safe care in many areas, including education, governance, incident management, reporting and learning, and improving best practice on the frontline. We are a small but mighty team capable of accomplishing great things. I am grateful for our outstanding partners of diverse sizes and goals, and the incredible, supportive network we have in the healthcare system. All of this makes my job easier in many ways.

In 2014, the Canadian Patient Safety Institute brought together key partners in Canadian healthcare and established the National Patient Safety Consortium to drive a shared action plan for safer healthcare. Out of this work came the Integrated Patient Safety Action Plan to articulate common goals and take the necessary actions to complete them. Today, more than 40 organizations are advancing this work, including national organizations, provincial and territorial quality and patient safety councils, government representatives, professional associations and patient groups. I am proud to say that overall of the 92 actions identified, 19 are complete and 45 are underway.

Unfortunately, many rural areas, especially Aboriginal and First Nation communities, don’t have access to the same resources as more urban centres. We need to do a better job understanding the needs of these communities and providing them with specific patient safety tools that they can use to make a difference in the lives of their patients. This work has only just begun and we’ll see much more on this in the coming year.

I am excited to share with you one of our major milestones of the past year. SHIFT to Safety, our new initiative to improve safety and quality of care in Canada, promotes a positive, safe healthcare experience for all our audiences in which to interact and take action. This major step forward encourages the public, healthcare providers, and healthcare leaders to use our specially developed tools and resources to help address patient safety issues and concerns every day. All resources are available free of charge on our website, patientsafetyinstitute.ca.

As a CEO, I could not ask for anything more than the talented, passionate team here at the Canadian Patient Safety Institute, and our Board of dedicated healthcare leaders. They make it possible for the Canadian Patient Safety Institute to explore evidence-informed approaches to governance and leadership and to share innovative health governance practices, resources, and tools. We pride ourselves on delivering high-quality programs. Together with our partners, we are making a positive change in the Canadian healthcare landscape.

Craig Power
Collaboration and Shared Leadership

The Canadian Patient Safety Institute has galvanized key partners in Canadian healthcare to focus on some of the biggest patient safety challenges and to align the work they are doing with some common goals in order to accelerate the pace of patient safety improvement. An Integrated Patient Safety Action Plan has been developed with an unprecedented level of collaboration and shared leadership involving almost 300 leaders from more than 100 organizations across Canada.
Integrated Patient Safety Action Plan

Beginning in January 2014, the National Patient Safety Consortium (Consortium) convened to drive a shared action plan for safer healthcare for Canadians. Eight pan-Canadian summits were held in 2014 and 2015 to identify specific actions to improve patient safety across the country. Primary areas of focus were pinpointed, including: surgical care safety, medication safety, home care safety and infection prevention and control. A roundtable was also held on patient safety education. By the end of each meeting, action plans were developed and multiple organizations agreed to serve as leads or co-leads. All of the action plans have since been woven into a single Integrated Patient Safety Action Plan.

Although specific themes were identified in each action plan to reflect the area of focus, when all of the actions are considered as a collective, four overarching themes were clearly evident:

- Patients and Families
- Providers, Leaders and Policy Makers
- Measuring and Learning to Improve
- Communicating

Significant progress has been made on the Integrated Patient Safety Action Plan. Today, more than 40 organizations are advancing this work, including national organizations, provincial and territorial quality and patient safety councils, government representatives, professional associations and patient groups. Overall, of the 92 actions identified, 19 are complete and 45 are underway.

An evaluation plan for the Consortium and Integrated Patient Safety Action Plan has been developed. The Evaluation Action Team is comprised of 16 partner organizations, including: the Academy of Canadian Executive Nurses, Health Quality Ontario, Canada Health Infoway, Mental Health Commission of Canada, Alberta Health, Canadian Agency for Drugs and Technologies in Health, Canadian Association of Paediatric Health Centres, Patients for Patient Safety Canada, and several others.

Following are some examples of the Consortium’s coordinated efforts during the fiscal year:

- One Action Team led by Health Quality Ontario looked at the top priorities for “never events” in healthcare. The Never Events for Hospital Care in Canada report garnered significant media attention across Canada (on every national news outlet) and abroad, with more than 30 million media impressions worldwide. In addition, there were 420 downloads of the report within the first two weeks after it was publicly released.

- Research suggests that leaders who want wide-scale change are more likely to be successful when an explicit model or theory of change is used. The Leading Large Scale Change environmental scan summarizes frameworks and strategies for leading large-scale change.

- Patient Safety and Quality Priorities for Consortium Participants: A Canadian Snapshot – this environmental scan demonstrates alignment and provides a high level summary of patient safety and quality priorities and goals for Consortium participants.
Our four strategies that will move patient safety forward in the Canadian healthcare system:

1. Provide leadership on the establishment of a National Integrated Patient Safety Strategy
2. Inspire and sustain patient safety knowledge within the system, and through innovation, enable transformational change
3. Build and influence patient safety capability (knowledge and skills) at organizational and system levels
4. Engage all audiences across the health system in the national patient safety agenda
**Surgical Care Safety**

More than one million surgical procedures were performed annually in Canada between 2004 and 2013. Over half of patient safety incidents in Canada are attributable to surgical care (Baker et al. 2004). The Surgical Care Safety Action Plan addresses key areas with the potential to make a significant impact in surgical safety: partnering with patients and families, teamwork and communication, measurement, advancing evidence-based clinical practices, and building quality improvement capability.

A major highlight of the past year involved the Canadian Medical Protective Association (CMPA) and the Healthcare Insurance Reciprocal of Canada (HIROC) conducting a retrospective analysis of Canadian surgical safety incident data. This analysis of medico-legal data advances knowledge in patient safety concepts and is intended to lead to system and practice improvements. Results and recommendations are contained in the summary report: Surgical Safety in Canada: A 10-year review of CMPA and HIROC medico-legal data. A deep dive into the methods, limitations and the results are found in the Detailed Analysis report.

**Medication Safety**

More than half of Canadians are using prescription drugs on a regular basis with 36 per cent taking two or more medications (Health Council of Canada 2014). Medication incidents continue to be the most frequently reported patient safety incident in Canada. The Medication Safety Action Plan focuses on four themes: reporting, learning and sharing; evidence-informed practices; partnering with patients; and technology. Almost two-thirds of the actions identified in the Action Plan are underway. Completed actions include:

- **In partnership with the Institute for Safe Medication Practices Canada (ISMP Canada), a working group was established to rebrand medication reconciliation (MedRec) as a component of medication safety and to develop a strategy to promote new products and services.**

- **Five Questions to Ask About Your Medications was produced in partnership with the Canadian Patient Safety Institute, ISMP Canada, Patients for Patient Safety Canada, Canadian Society of Hospital Pharmacists and the Canadian Pharmacists Association.** The questions are designed for the public and providers to communicate about safe medication use.

A white paper is being developed by the Canadian Institute for Health Information (CIHI) and ISMP Canada that identifies all of the separate reporting systems used to collect medication incident data. This valuable information will suggest how medication incident information from multiple sources can be pooled, synthesized and shared more effectively.
Home Care Safety

Participants of the Home Care Roundtable developed an action plan focused on four themes:

- **System Level Communication** – Initial meetings have been held and timelines developed under the leadership of Saint Elizabeth Health Care.
- **Client’s Right to Live at Risk and Partnering with Clients and Families** – Initial work examined the principles and a report has been produced. Am I Safe? is a tool now being developed to manage difficult conversations. It will be released in 2016.
- **Advance Knowledge of Measurement for Improvement** – CIHI is leading this work. A studentship was awarded to Dr. Paul Stolee (University of Waterloo) to examine the current use of quality and safety data in the Home Care sector. CIHI is also examining its internal educational offerings and exploring alternative options for making their resources more accessible to the Home Care sector.
- **Leading Practices in Medication Safety, Falls Prevention, and Infection Prevention and Control** – Significant work has been completed to incorporate new and emerging evidence in medication safety and falls prevention in Home Care, and to align this work with Safer Healthcare Now! and the Home Care Safety Falls Prevention Virtual Improvement Collaborative.

Infection Prevention and Control

The Canadian Patient Safety Institute continues collaboration with key partners including the Public Health Agency of Canada and Infection Prevention and Control Canada to improve infection prevention and control safety practices, and reduce healthcare associated infections in Canada. Over the past year, the Infection Prevention and Control (IPAC) Action Teams have collaborated and made progress on two actions: conducting an environmental scan to set the groundwork for a national campaign focused on behavioural change; and the creation of a pan-Canadian set of case definitions for the surveillance of healthcare associated infections. Work is underway with key stakeholders to review the current set of definitions in acute care and long-term care. The 2015-16 fiscal year has been foundational, setting the stage for future activities within the IPAC Action Plan.

Patient Safety Education

Patient safety education is the cornerstone of a future generation of healthcare professionals ingrained with the practices and principles of patient safety. The Patient Safety Education Action Plan addresses patient safety priorities and aims to support faculty with the tools and resources to ensure that patient safety and quality improvement are embedded within healthcare curricula. The group is looking to influence system level change in health professional education in Canada through health professional faculty and educator development in patient safety science, and also by leveraging the Patient Safety Education Program – Canada, Advancing Safety for Patients in Residency Education program, Safety Competencies Framework, LEADS in a Caring Environment Framework, and other curricula. A Patient Safety Education Network is being established to provide a common platform for educators to build a community, and create greater alignment and influence for patient safety education across Canada.

Progress on 2014-2016 Actions

Year One (as of March 31, 2016)
(Actions to be completed by 2018)

12 Patient Safety Education actions
with 10 Leads / Co-Leads and 55 Partner Organizations participating. Two Patient Safety Education Roundtable meetings creating a community of educators.

Key accomplishments include the release of the following sentinel tools and reports:
- Never Events for Hospital Care in Canada.
- Five Questions to Ask About Your Medications.
- Surgical Safety in Canada: A 10-year review of CMPA and HIROC medico-legal data.

Overall progress on the Integrated Patient Safety Action Plan
(as of March 31, 2016)
(Actions to be completed by 2018)

- **Infection Prevention and Control**
  - 17% complete
  - 83% remaining

- **Medication Safety**
  - 44% complete
  - 56% remaining

- **Surgical Care Safety**
  - 29% complete
  - 71% remaining

- **Patient Safety Education**
  - 7% complete
  - 93% remaining
The Canadian Patient Safety Institute values patients and families as an integral part of patient safety improvement at all system levels, in all healthcare settings. Patient involvement is part of everything that we do – all Canadian Patient Safety Institute programs and initiatives meaningfully and authentically involve patients in their development and/or delivery.
Building strong partnerships is the hallmark of Patients for Patient Safety Canada and it is these partnerships that are making a real difference in changing the culture of patient safety. Patients for Patient Safety Canada reached a significant milestone, celebrating its 10th Anniversary in April 2016.

The mandate of this patient-led program of the Canadian Patient Safety Institute and the Canadian arm of the World Health Organization (WHO) Patients for Patient Safety programme is to represent the patient perspective to advance patient safety improvements at all levels. The Patients for Patient Safety Canada network is made up of more than 70 patient and family members, most of whom have experienced harmful incidents and so have a deep desire to prevent harm and improve the quality and safety of healthcare. They volunteer their time to act as trusted partners to champion patient safety and patient-centered care.

Some 94 per cent of the Canadian Patient Safety Institute’s programs, including the Integrated Patient Safety Action Plan, have been developed and implemented or delivered with Patients for Patient Safety Canada participation. Patients for Patient Safety Canada members participated in more than 100 collaborations to provide the patient and family perspective at all levels of the health system in Canada and around the world, including conference speaking engagements, working groups, committees and boards, national campaigns, and educating healthcare providers and leaders. A highlight during the year was the inclusion of patient input into the curricula of HealthCareCAN’s new learning programs on patient engagement and incident management, which have the real potential to change behaviours and outcomes for both learners and the organizations where they work. Another highlight of the year was Patients for Patient Safety Canada’s continued contribution to Accreditation Canada’s Required Organizational Practices and Standards, which has had a positive ripple effect across the country and around the world.

Patients for Patient Safety Canada’s member-driven Knowledge Transfer Working Group designed, developed, delivered and evaluated three international webinars in partnership with the WHO. These highly-attended webinars were delivered by patients, for patients, and included participation from providers and healthcare leaders.

The WHO has recognized Patients for Patient Safety Canada as the strongest in-country network of patient advocates anywhere in the world. Fifteen Patients for Patient Safety Canada members achieved the WHO Patient Safety Champion designation in March 2016; a total of 37 Patients for Patient Safety Canada members currently hold this unique designation.

The Patient Safety Champion Awards are presented annually by HealthCareCAN and the Canadian Patient Safety Institute, with support from Patients for Patient Safety Canada, to recognize partnerships between patients and providers.
The 2015 Patient Safety Champion Organization Award was presented to Providence Health Care. Providence includes patient and family partners in many aspects of their planning and operational decision-making in relation to the hospital and inpatient experience. More than 200 patient and family partners participate in about 80 activities hospital-wide. The Care Experience Strategic Direction Committee strives to promote patient and family engagement in all aspects of care, which is driven by four core values: respect and dignity, information-sharing, participation, and collaboration. The Committee includes six patient and family partners who have helped to shape and design the strategies that support the hospital’s strategic direction.

The 2015 Patient Safety Champion Individual Award recipient was the Price family, nominated by the Health Quality Council of Alberta. Dave, Isabelle, Teri, Joanna, Chad and Matthew Price work tirelessly to share the journey of the sudden and untimely death of their son and brother, 31-year old Greg. Their resolve to inform others about the problems in continuity of care will help to encourage improvements to Alberta’s health system overall. The passion and unwavering commitment of his parents and siblings honours Greg’s memory, while advocating for the changes necessary for patient-centered healthcare.
70 volunteer patient members

29 speaking engagements at 18 Canadian events to tell their stories and share their experiences.

Participated in 29 committees, boards or working groups
21 of those at a national level.

Contributed to the design, development and implementation of 27 products, such as policies, strategies, programs and campaigns; 17 at a national level.

Designed, developed, delivered and evaluated 3 international webinars with the World Health Organization, attended by approximately 300 participants in total.

15 members achieved the WHO Patient Safety Champion designation in March 2016; 37 of 70 Patients for Patient Safety Canada members currently hold this unique designation.
Achieving safe healthcare for all Canadians requires everyone’s involvement. The Canadian Patient Safety Institute connects patients and families, patient advisors, healthcare providers, leaders and organizations so that they can share, learn and help others.
Global Patient Safety Alerts

Healthcare leaders, providers and the public can access valuable evidence-informed solutions and strategies to help manage patient safety incidents in their organization and connect with others to learn and share. Global Patient Safety Alerts is an online collection of patient safety incidents containing more than 1,200 alerts and 6,100 recommendations from 26 contributing organizations around the world. The goal of Global Patient Safety Alerts is to ensure that no one is stuck without a solution to a problem that others have already solved, and that no patient needlessly suffers harm as a result.

Over the past year, there were almost 12,000 views of specific alert summaries from users in 100 countries around the world. To simplify and facilitate learning across jurisdictions, presentations were made to health quality councils, regional health authorities and hospitals across Canada and to patient safety leaders from Australia, Japan, Jordan, Kuwait, Lithuania, Oman, Sri Lanka, Vietnam and the WHO. Moving forward, the program will communicate trends and utilize current data to better understand emerging patient safety issues being reported and shared in Canada and around the world.

Measuring Hospital Harm

To date, there has been no standard approach to measuring and monitoring harm and the safety of Canadian hospitals. CIHI and the Canadian Patient Safety Institute are looking to address this using administrative data to develop a new way of reporting and improving on patient safety for acute care hospitals that will provide system decision-makers, hospital executives, clinicians and policy makers with access to important information on how to address potential areas of concern, promote transparency and open conversations about improving patient safety.

CIHI is developing a new facility-level measure intended to monitor variations in patient safety in inpatient acute care settings. It is designed to assist organizations to identify patient safety improvement priorities and track progress over time. The measure is being developed in close consultation with hospitals, clinical experts, and experts in coding and data quality, and integrates extensive research, prototype testing and expert consultation.

The Canadian Patient Safety Institute is developing the Hospital Harm Improvement Resource to complement the hospital harm measure and link measurement to improvement by providing evidence informed resources that will support patient safety improvement efforts. The Hospital Harm Improvement Resource is being produced in collaboration with Patients for Patient Safety Canada, Accreditation Canada, and the Canadian Association of Pediatric Health Centres.

An analytical report will introduce this new approach to measuring hospital harm and link the framework to the Improvement Resource. The analytical report and Improvement Resource will be released in October 2016.

Comments from the Hospital Harm working group participants on the Improvement Resource

“This appears to be an excellent resource. The section on the importance to Patients and Families, for communication purposes, and the metrics/process metrics sections were particularly helpful.”

“This document helps create a framework for using best practices and suggested meaningful audits to analyze and identify areas of needed improvement. A document with relevant resources listed is beneficial in saving time and allow staff to organize and react more quickly to apparent risks and reducing further harm. Resources that include best practice and evidence-based practices will improve our decision on future planning and current practices.”

“Appreciate all the general resources listed, the specific best practice guideline and then all the references. It creates a one-stop shop reference centre. Would really help save clinicians’ research time when they choose an area to improve.”
Research

The Canadian Patient Safety Institute creates new conversations through papers and commissioned research. By increasing the scope and scale of patient safety research, the Canadian Patient Safety Institute is building capacity for quality research that will lead to significant health system improvements across the continuum of care.

Commissioned research was awarded by the Canadian Patient Safety Institute, Accreditation Canada, HealthCareCAN, and the Canadian Home Care Association to Dr. Andrew Costa for the ground-breaking work, “The Transition from the Emergency Department into Home Care (Trans-Ed-HC) Project: A Mixed Methods Study of Patterns of Patient Safety Events and Transition Processes.” The study investigates what impedes and what creates successful care transitions. The final report, along with tools and resources to aid in knowledge translation, will be released in the summer of 2016.

The Canadian Patient Safety Institute, Accreditation Canada, the Canadian Home Care Association, Patients for Patient Safety Canada, and the Registered Nurses’ Association of Ontario awarded $50,000 to Dr. Chantal Backman of the University of Ottawa and her research team for the 2015-16 Research Competition study, “Safe and effective person-and-family-centered care practices during transitions between hospital-based care and home care – A mixed methods study.” Using person and family-centered approaches to care, this research aims to explore how patient safety is operationalized and monitored during transitions in care. The final report is due in July 2017.

Studentships

A cornerstone of Canadian Patient Safety Institute sponsored research is the participation of patients, providers and leaders in all aspects of the research process, helping to support the translation of the knowledge into practice. Studentships help advance the next generation of researchers who possess an interest in patient safety.

Four Studentships were awarded, engaging master’s and PhD students whose work will support actions outlined in the Integrated Patient Safety Action Plan. The recipients are Dr. Paul Stolee (University of Waterloo), Dr. Sherry Espin (Ryerson University), Dr. Jan Davies (University of Calgary) and Dr. Nancy Marlett (University of Calgary).
INFOGRAPHIC: Sharing and Learning

12,000 views of specific Global Patient Safety Alerts summaries + 100 countries around the world with Global Patient Safety Alerts users

Global Patient Safety Alerts is a growing repository of

1,200 alerts 6,100 recommendations 26 contributing organizations worldwide

$50,000 awarded to Dr. Andrew Costa and his research team for ground-breaking work: “The Transition from the Emergency Department into Home Care (Trans-Ed-HC) Project: A Mixed Methods Study of Patterns of Patient Safety Events and Transition Processes”.

$50,000 awarded to Dr. Chantal Backman of the University of Ottawa and her research team for the study entitled: “Safe and Effective Person and Family-Centred Care Practices during Transition between Hospital-based Care and Home Care – A mixed method study”.

4 Studentship awards engaging master’s and PhD students to support actions of the Integrated Patient Safety Action Plan.
The Canadian Patient Safety Institute showcases its work and initiatives by exhibiting and speaking at national conferences and learning events. This direct, in-person connection with all levels of the Canadian healthcare system promotes collaboration and a shared purpose. The Canadian Patient Safety Institute participated in 24 events, ranging from a few hundred to more than 1,000 delegates, where partnerships were strengthened and new relationships forged.
Building collaborative partnerships in Atlantic Canada

The Canadian Patient Safety Institute participates in and provides secretariat support to the Atlantic Health Quality and Patient Safety Collaborative. The Atlantic Health Quality and Patient Safety Collaborative was established in 2010 by the Atlantic Deputy Ministers of Health, to share resources and reduce duplication of efforts. The Atlantic Health Quality and Patient Safety Collaborative aids in facilitation, capacity building, forming relationships and knowledge exchange to advance patient safety and quality improvement in Atlantic Canada. The Atlantic Health Quality and Patient Safety Collaborative is key to building collaborative partnerships across the four Atlantic provinces.

Through the Atlantic Learning Exchange local quality and patient safety excellence is profiled. In May 2015, 185 healthcare professionals attended the Atlantic Learning Exchange, where 11 rapid fire and 11 storyboard presentations profiling local improvement success were recognized. Planning is already underway for the next Atlantic Learning Exchange to be held in May 2017.

Supporting patient safety cultural changes in Ontario

The Canadian Patient Safety Institute works collaboratively with many key partners in Ontario to advance a culture of safety and quality improvement. Ontario is a leader with respect to patient safety reporting and legislation that supports patient safety improvement. The province recently undertook a renewal of its Quality of Care and Information Protection Act. Changes to the new legislation will renew leading practices in full disclosure to patients and families following critical incidents and support the engagement of patients and families, providers, and leaders in the process of learning from critical incidents.

In 2015-16, the Canadian Patient Safety Institute participated in a number of key patient safety initiatives in Ontario, including: Responding to and Learning from Patient Safety Incidents – Building a Just Culture of Trust and Transparency (a panel discussion at the Ontario Health Association Health Achieve Conference, 2015); Why is Patient Safety so Hard? Approaches to Improving Patient Safety by Establishing High Reliability Organizations (a panel discussion at the Health Quality Ontario Health Quality Transformation, 2015); Critical Incident Reviews and Disclosures: The Intersection of Legislation (group discussion at the Ontario Hospital Association conference, 2016); Patient Safety Incident Learning System Working Group (led by Health Quality Ontario for the Ministry of Health and Long Term Care); and the Acute Care Patient Safety Indicator Review Advisory Panel (established by Health Quality Ontario).

Advancing key priorities in Western Canada

The Canadian Patient Safety Institute provides leadership and support to the Western Quality and Patient Safety Representatives Group, a collaborative of the Western Healthcare CEO Forum, comprised of members from the Regional Health Authorities from British Columbia, Alberta, Saskatchewan and Manitoba. This group identifies, discusses, and shares information, experiences and initiatives in quality and patient safety in order to effectively learn from each other and advance key priorities in Western Canada and to better coordinate and align patient safety and quality work across the regions. The Canadian Patient Safety Institute also participated in several provincial forums, conferences, learning events, webinars and judging panels with the quality and patient safety organizations and regions in the Western provinces.

Feedback from Atlantic Learning Exchange participants:

"Loved the learning experience. Received lots of ideas that ignite my enthusiasm for my organization."

"Having both a patient perspective and the accompanying administrative/quality perspective was extremely effective. Such an excellent roster of speakers and topics. Well done!"

"So relevant to practice; wonderful opportunity to share and learn from our Atlantic partners. Loved the rapid fire presentations."

"Variety of topics with broad range of applications. I am from long term care and I appreciated that topics such as disclosure and patient engagement can be applied in that environment. Nice that the conference was not just ‘hospital focused.’"
Safer Healthcare Now!

Safer Healthcare Now! was launched in 2005 as a resource for frontline healthcare providers, health organizations, health quality committees and councils, and health ministries to prevent patient safety incidents. The Safer Healthcare Now! interventions are a series of customizable, reliable, tested and practical tools for improving quality and patient safety that combine clinical and patient safety improvement expertise. The current offerings of Safer Healthcare Now! are now archived and a new platform has been created to help implement, measure, and evaluate patient safety initiatives.

In July 2016, SHIFT to Safety was launched as the go-to source for patient safety. The platform focuses on the entire health system, including patients, families, providers and leaders as target audiences for its offerings. SHIFT to Safety was created to address the gap in the health system between clinical knowledge and best practices and to shift the focus of quality improvement to behavioural change strategies, empowering individuals within the system to make sustainable change. All Safer Healthcare Now! tools and resources have been mapped to the new platform to ensure continuity with current Canadian Patient Safety Institute programs.

During the 2015-16 fiscal year, learning sessions for the first wave of the Safer Healthcare Now! Home Care Safety Falls Prevention Virtual Improvement Collaborative were completed with five teams participating. The Collaborative was delivered in partnership with the Canadian Home Care Association, the Canadian Foundation for Healthcare Improvement, the Canadian Institute for Health Information, Accreditation Canada, ISMP Canada, and the Registered Nurses’ Association of Ontario. The second wave of this work will continue in 2016-17.

With leadership from the Critical Care Faculty, a national Pain, Agitation and Delirium Collaborative was launched in March 2016, with 44 teams from across the country participating, including 10 pediatric centres. The Collaborative will extend into next year.

Eight National Calls were delivered in partnership with the intervention leads and faculty on a variety of topics, including: patient engagement, hand hygiene, medication safety, safe surgical care, home care, and end of life care. In partnership with Alberta Health Services, the Canadian Patient Safety Institute hosted one of the most successful calls in April 2015, “When Caring Hurts; Helping Helpers Heal.” Nearly 1,000 sites joined the webinar to learn about the second victim in patient safety incidents.

A new Infection Prevention and Control Faculty and Expert Lead were recruited to further support the Infection Prevention and Control strategy. In 2015-16, the primary focus for the faculty was to conduct an environmental scan to assess existing infection prevention and control tools and resources, and identify opportunities for improvement.

The Surgical Safety Checklist Working Group has a commitment from the Canadian Medical Protective Association, Accreditation Canada, the Operating Room Nurses Association of Canada, the Canadian Anesthesiologists’ Society and Alberta Health Services to develop a position statement endorsing the effective use of the Safe Surgery Checklist.

Two Getting Started Kits were launched in 2015-16, a new Sepsis Getting Started Kit and a revised Improvement Frameworks Getting Started Kit.
Measuring for Patient Safety and Quality Improvement

Two National Quality Audit Month events were held: the Falls Prevention Audit was held in April 2015 with 152 teams participating and 3,499 charts audited; and the first ever Surgical Site Infection audit was held in February 2016 with 52 service areas submitting data for 1,998 patients.

Measurement is a critical component of the improvement process. Without measurement, there is no way of knowing whether quality initiatives are leading to improved care. The Canadian Patient Safety Institute is moving from supporting a measurement database and providing measurement consultation to an expert measurement consultation approach that leverages the most up-to-date thinking related to the measurement and monitoring of patient safety.

Under the guidance of Professor Charles Vincent (Oxford University, UK) and Dr. G. Ross Baker (University of Toronto) the Canadian Patient Safety Institute is developing a comprehensive measurement program based on Vincent’s A Framework for Measuring and Monitoring Safety. The framework specifies five elements required for safety measurement and monitoring: past harm, reliability, sensitivity to operations, anticipation and preparedness, and integration and learning. The measurement platform will focus on guiding leaders, practitioners, patients, families and informal caregivers to find local and system level answers to how they can prevent harm, respond to harm and learn from harm through the application of the framework.

Comments from the Falls Prevention Audit participants:

“The Canadian Patient Safety Institute’s Falls Prevention and Injury Reduction audit tool was the perfect fit. We liked the questions, the tool and the information it would provide for us.”

“An audit is a big task that can be daunting and overwhelming. It is not easy to start and like anything you do for the first time; you will always have some glitches. It was a learning process and like any quality improvement initiative, there are going to be challenges and you have to work through them. I could have thrown in the towel, but I saw value in the audit. The next time we audit, we will keep improving and our data will reflect that.”
5 teams participated in Home Care Safety Falls Prevention Virtual Improvement Collaborative.

44 teams including 10 pediatric centres, participated in a national Pain, Agitation and Delirium Collaborative in Critical Care.

1,286 organizations enrolled in Patient Safety Metrics, with 538 organizations actively submitting data for 2015-16.

2 Getting Started Kits launched a new Sepsis Getting Started Kit and an updated Improvement Frameworks Getting Started Kit.

17% of teams submitting data to Patient Safety Metrics met and maintained improvement goals within 24 months of their first submission.

3 NEW data collection tools to support local measurement: MedRec in Home Care, MedRec at Discharge, and Central Line Insertion and Central Line Maintenance.

2 National Audits hosted:

152 acute care, long-term care and home care participants in the Falls Audit with 3,499 charts audited:

- over 80% of patients/residents/clients had a fall risk assessment completed.
- only 10% of audited patients in acute care experienced a fall, while 30 per cent from long-term care reported having one or more falls during the reporting period.

52 service areas participated in the Surgical Site Infection Audit with 1,998 patient charts audited:

- 91% of patients received appropriate prophylactic antibiotics.
- 96% of patients received the appropriate method of hair removal.
- 95% of patients had good temperature control after surgery.

Post-operative glucose control is an area requiring improvement.
The Canadian Patient Safety Institute works with its partners to identify and support the integration of leading patient safety practices into education, training and professional development for undergraduate, post-graduate and practicing healthcare professionals across the continuum of care.

Advancing patient safety education is the cornerstone of a future generation of healthcare professionals ingrained with the practices and core principles of patient safety. The Canadian Patient Safety Institute continues to support faculty in educational institutions across the country, providing tools and resources to ensure that safety competencies are embedded within healthcare curricula.
Patient Safety Education

The Patient Safety Education Program – Canada (PSEP – Canada) takes an interprofessional team approach to improving patient safety skills and planning patient safety education aligned with quality improvement initiatives. On completion of the PSEP – Canada two-day program, participants are armed with a full patient safety education curriculum, learning tools and customizable presentations that can be adapted to their local patient safety work.

PSEP – Canada is built on a train-the-trainer approach, providing a peer-to-peer education framework for participants. Since the program was introduced in 2011, some 777 PSEP – Canada trainers have been certified to educate and spread patient safety knowledge. The PSEP – Canada program is flexible, with a broad curriculum of over 35 modules on patient safety topics. Working with stakeholders within the healthcare system, master facilitators can tailor their sessions to the needs found across the continuum of care. The curriculum is reviewed and revised on a regular basis and new modules are added to ensure the curriculum remains current and relevant.

The PSEP – Canada program continues to evolve to meet the specific patient safety learning needs of healthcare regions and organizations. In 2015-16, four PSEP – Canada conferences were delivered, including those focusing on northern Ontario communities, as well as collaborating with Alberta Health Services (Integrated Quality Management, Edmonton Zone). Currently, PSEP – Canada is working with a pediatric centre to customize a session for family advisors.

The Manitoba Institute for Patient Safety became a PSEP – Canada affiliate partner, joining the Canadian Forces Health Service Group and Queen’s University in Kingston, Ontario.

Comments from Thunder Bay participants:

“Facilitators were amazing, inspirational.”

“I learned a great amount and will apply this knowledge in my everyday work.”

“It reinforced my passion for patient and workplace safety.”

Comments from Edmonton participants:

“Excellent course!”

“Doing presentations using the PSEP material will help to promote patient safety and system thinking at the front line, which in turn helps staff to recognize the importance of reporting and continuous improvement.”
The PSEP – Canada Innovations in Patient Safety Education Award provides an opportunity for individuals and healthcare organizations to share and be recognized for their work in patient safety education. Award recipients are selected based on how their specific education initiatives, along with the use of the PSEP – Canada program enhances patient safety education in their organization and yields leading practices that are scalable and can be adapted to other healthcare organizations across the country.

The Power of an Organization 2015 recipient was Sunnybrook Health Sciences Centre. The Sunnybrook iLead Quality & Patient Safety Program helps to equip and motivate frontline staff of all professions to engage in effective quality and patient safety improvement activities. Sunnybrook has developed two certificate programs that focus on quality improvement methods, measurement, systems thinking, human factors, change management, Lean, FMEA, Root Cause Analysis and other essential patient safety science practices. Themes of teamwork and communication, interprofessionalism, safety culture and patient/family engagement are interwoven throughout the entire curriculum.

The Power of One 2015 was awarded to Jennifer Newitt (Prairie Mountain Health). Jennifer is a skilled educator who sees the abilities in others to improve the safety of care. As a Regional Clinical Educator, Jennifer incorporates the PSEP – Canada curriculum into everyday practice, including: embedding content into hand hygiene education for Nursing Skills Blitz Days, utilizing the medication safety content for Home Care medication education for Home Care Attendants, helping educator colleagues to integrate the curriculum into their education sessions, and leading sessions as an instructor for the regional PSEP Patient Safety Ambassador course.
Safety Competencies

The Safety Competencies have been successfully incorporated into hundreds of education programs and professional development opportunities. A strategy of mapping educational programs to the Safety Competencies was designed and adopted by senior leaders in faculties and schools who were willing to demonstrate their support of the Safety Competencies Framework by agreeing to complete an analysis of their undergraduate and clinical education programs.

By mapping their programs, standards or curricula, organizations, faculties and schools realized that this was an important first step in integrating safety content in healthcare education. Focusing on integration of the Safety Competencies allowed organizations to identify the desired knowledge, skills, and behaviours in patient safety education at a more granular and explicit level. Mapping allowed for program strengths to be identified, as well as to highlight training gaps related to patient safety.

Interviews were completed with a select group of stakeholders familiar with the Safety Competencies Framework and the mapping project that provided a better understanding of the value of the competencies to academia, national health organizations and professional bodies. Interviews also provided insight into the benefits of the e-mapping process and suggestions for future editions of the Safety Competencies Framework. The Canadian Patient Safety Institute will invest in a modest revision of the Framework, including reviewing existing content, and soliciting feedback from members of Patients for Patient Safety Canada and the patient safety education community on the successes and challenges of integrating patient safety content into curricula and practice settings.

Advancing Safety for Patients in Residency Education

The Advancing Safety for Patients in Residency Education (ASPIRE) program was developed collaboratively with the Royal College of Physicians and Surgeons of Canada and the Canadian Patient Safety Institute. ASPIRE is a high impact, four-day comprehensive program, designed to support the work of medical educators to deliver patient safety and quality improvement content.

With the release of the CanMEDS Physician Competency Framework in October 2015, the ASPIRE curriculum was revised to align with and support the CanMEDS Framework. In addition, a recent partnership with Choosing Wisely Canada will enable the addition of crucial resource stewardship content into the ASPIRE program.

In November 2015, an educational session was delivered to 40 participants in partnership with the Collège des Médecins du Québec. The French session was supported by a number of well-respected quality and patient safety healthcare professionals from the province of Quebec.

Feedback from ASPIRE participants:

"I'm leaving with lots of ideas about how to better teach patient safety; thank you for this wonderful program."

"Lots of ideas/suggestions/projects/tools were presented – thank you!"

"Congratulations on your joint efforts and thanks for having passed on your knowledge to us so effectively."
Incident Management

The Patient Safety and Incident Management Toolkit, launched in May 2015, is a web-based resource for healthcare organizations that provides an integrated set of practical strategies and resources related to patient safety and incident management. In 2015-16, there were almost 30,000 page views and 474 downloads of the PDF document.

The Canadian Patient Safety Institute is working with the Atlantic Health Quality and Patient Safety Collaborative to develop a pilot Incident Management Education Program using the Patient Safety and Incident Management Toolkit. A two-day program will be delivered in October 2016 to participants from the four Atlantic provinces.

Innovative knowledge translation strategies are being explored to position the Patient Safety and Incident Management Toolkit as a rich resource, providing actionable activities and direction for healthcare providers and leaders. A national needs assessment will be undertaken to explore gaps in the system in order to develop a Patient Safety and Incident Management Education Program that complements the full spectrum – from prevention, to reporting and learning.
Canadian Patient Safety Officer Course

The Canadian Patient Safety Officer Course, jointly developed and delivered by the Canadian Patient Safety Institute and HealthCareCAN, is supported by experts from across Canada and internationally. The course provides an overview of the fundamentals of patient safety and equips both healthcare professionals and leaders with the information, tools and techniques to build a strong patient safety culture. Upon completion, graduates are equipped to effect the system change required to advance patient safety within their organization. The program is available in two delivery models: in-person or online.

To date, 426 participants from all Canadian provinces and territories and 20 international participants have completed the program. The 2015-16 program was attended by 41 participants, including three international students. By the end of the course, participants created an action plan to address an aspect of patient safety in their organization. In a 2015 six-month follow-up survey, 100 per cent of participants responding reported the use and/or implementation of a tool or practice within their organization that was introduced during the Canadian Patient Safety Officer Course.

Comments from Canadian Patient Safety Officer Course participants:

“The course was a pleasure to attend. It was impeccably organized and delivered by a robust group of experts. I am looking forward to applying these tools in my workplace.” In-person Participant

“One learning that I will take away is that we must make time for safety. For ourselves, for our peers and colleagues, and for those who work on the front line every day – when we make time (and talk about) safety, we will create the space where we can improve.” Online Participant

“This program has helped me to move my patient safety and quality initiatives off the side of my desk and more into the middle to embed these principles into everyday practice.” Online Participant
Effective Governance for Quality and Patient Safety

To support boards in their efforts to improve governance for quality and patient safety, the Canadian Health Services Research Foundation (now the Canadian Foundation for Healthcare Improvement) and the Canadian Patient Safety Institute developed the Effective Governance for Quality and Patient Safety program – a toolkit and education session to help healthcare boards understand and implement effective governance practices and processes for quality and patient safety.

The Effective Governance for Quality and Patient Safety program is designed for board members of healthcare organizations and the leadership teams with whom they work. It offers participants access to expert peer facilitators, a network of like-minded individuals, time to reflect on their current governing practices, development of an action plan and practical tools and resources they can bring back to their organization.

Program participants learn to:

- Understand a Board’s core functions related to quality and patient safety.
- Identify approaches to measuring the quality of care.
- Recognize how a culture of quality and patient safety within an organization can be led, supported and sustained by the Board.
- Identify tools, structures, processes and priorities that will assist participants in improving their organization’s governance practices related to quality and patient safety.

The Association of Family Health Teams Ontario delivered the Effective Governance for Quality and Patient Safety program as part of their annual conference in October 2015, with 70 participants in attendance. A partnership with the Ontario Hospital Association resulted in the delivery of a one-day, pre-conference session at Health Achieve 2015, where 45 participants from various sectors completed the program. On average, in 2015-16 more than 90 per cent of participants said they would recommend this session to a colleague and more than 90 per cent reported an increase in knowledge as a result of participating in the program.

A two-day, train-the-trainer session held in January 2016 certified seven trainers from the Ontario Hospital Association to deliver the Effective Governance for Quality and Patient Safety program in Ontario.

There were 150 Effective Governance for Quality and Patient Safety Toolkits distributed and 12,496 page views of the Effective Governance for Quality and Patient Safety web page.
Considerably more time is devoted to the quality discussion and the quality report is a standing item on the agenda and is now at the top of the board meeting agenda instead of buried at the end.

“We had always placed responsibility on management – now we as a board understand our governance role in quality and patient safety.”

“Raising the level of Board education around quality and patient safety has changed the discussion considerably. Board members are quite excited now to see the progress and feel comfortable engaging in discussion.”

“The greatest success identified was moving the quality report to the top of the agenda. They believe it reminds everyone how important the topic is. It was easy to do and had a big impact.”

“Sharing of information in a just culture. Improved communication with physicians, families, and patients. Physicians are engaged with the process of reviewing processes, improving processes and making changes. Culture is beginning to change. No longer pointing fingers, but looking at doing better.”
Effective Governance for Quality & Patient Safety (EGQPS) participants:

- 45 attendees at pre-conference program at Health Achieve 2015.
- 70 participants from the Association of Family Health Teams Ontario.
- 7 Ontario Hospital Association trainers completed a two-day, train-the-trainer session to deliver the EGQPS program in Ontario.

Patient Safety and Incident Management Toolkit

- 29,476 page views
- 474 PDF downloads

of the Patient Safety and Incident Management Toolkit since its launch in May 2015.

Participants attended an Advancing Safety for Patients in Residency Education (ASPIRE)

French educational session in November 2015, offered in partnership with the Collège des Médecins du Québec.

To date 426 Canadian participants and 20 international participants have completed the CPSOC; 100 per cent reported the use or implementation of a tool or practice introduced at the CPSOC within their organization.

New patient safety trainers certified at 4 Patient Safety Education Program – Canada (PSEP – Canada) conferences.

31 organizations across the country participated.
Canadian Patient Safety Week

Canadian Patient Safety Week is a nationally-designated annual campaign, sponsored by the Canadian Patient Safety Institute and GOJO, to inspire extraordinary improvements in patient safety and quality across the country. Now in its 11th year, Canadian Patient Safety Week brings attention and awareness to the fact it is estimated that more than 31,000 Canadians die every year because of preventable harm in healthcare including infections, drug reactions and surgical incidents.

The 2015 Safety Week theme, Good communication is good for your health, focused on two-way communication between patients and providers and how to keep care safe. Some 1,178 healthcare organizations participated, with many hosting local events to promote Canadian Patient Safety Week.

Ask.Listen.Talk. is the overarching theme for Canadian Patient Safety Week. Improving communication in healthcare starts with Ask.Listen.Talk. It is a conversation where healthcare providers are taking part. During the week, providers wore buttons asking patients “Did you ask me everything you wanted to today?” and copies of the award-winning magazine, Hands in Healthcare, as well as tent cards that included 5 Tips to get you Talking were distributed.

Canadian Patient Safety Week 2016, will be held October 24-28, 2016. The theme of the 2016 campaign is Questions Save Lives.

Canada’s Virtual Forum on Patient Safety and Quality Improvement

For the past six years, Canada’s Virtual Forum on Patient Safety and Quality Improvement has showcased some of the brightest minds in healthcare and provided a unique opportunity to share great ideas to advance patient safety. The proceedings are freely available online to anyone from anywhere, requiring only an internet connection. Held October 28-30, 2015, Canada’s Virtual Forum was attended by more than 1,100 viewers from 600-plus sites in Canada and six other countries. A total of 46 speakers were featured during 15 hours of programming.

Since its inception in 2010, Canada’s Forum has inspired many as guardians of patient safety. With so many offerings in a crowded virtual learning environment, the Canadian Patient Safety Institute is retiring the event, knowing that its legacy is the unparalleled momentum for patient safety and quality improvement that has been generated in the Canadian healthcare system.

Feedback from Canadian Patient Safety Week participants:

“ It gets better every year and is one of the highlights of my professional year.”

“I love this event! It is my annual dose of inspiration. Keep up the great work!”

“This is an excellent way to engage the country in patient safety.”

Feedback from Canada’s Forum participants:

“This was a great event. Excellent speakers. Excellent organization. The best conference I have attended in the past 5 years.”

“This is a wonderful initiative. Even if it is difficult for my organization to fully participate... Your work is greatly appreciated.”

“Interesting, wish I had more time to see it all, but I will look at the recorded sessions as time allows.”
Canadian Patient Safety Week (CPSW) registrants: 1,178

- 150,000 copies of Hands in Healthcare magazine distributed.
- 276,000 broadcast emails sent to 11,000 subscribers; 43 per cent of survey respondents learned about CPSW from emails.
- 1,100 viewers from over 600 sites in Canada and 6 other countries.
- 408 viewers from 295 Canadian sites have accessed the broadcast archives since mid-November.
- 80% of participants said the virtual environment worked for them.
- 79% of participants were satisfied with the quality of speakers.
- 70% of participants said what they learned was applicable to their work.
- 25,341 website visits to the Canadian Patient Safety Week and Canada’s Forum webpages.
- 3.1 million impressions of #asklistentalk with 1,507 original tweets from 407 unique users.

To the Board of Directors of Canadian Patient Safety Institute

The accompanying summarized financial statements, which comprise the summarized statement of financial position as at March 31, 2016, and the summarized statement of operations for the year then ended, and related notes, are derived from the complete set of audited annual financial statements of Canadian Patient Safety Institute for the year ended March 31, 2016. We expressed an unmodified audit opinion on those financial statements in our report dated June 17, 2016. Those financial statements, and the summarized financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The summarized financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summarized financial statements, therefore, is not a substitute for reading the audited financial statements of Canadian Patient Safety Institute.

Management’s Responsibility for the Summarized Financial Statements

Management is responsible for the preparation of a summary of the audited financial statements on the basis described in the notes to the summarized financial statements.

Auditor’s Responsibility

Our responsibility is to express an opinion on the summarized financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard 810, Engagements to Report on Summary Financial Statements.

Opinion

In our opinion, the summarized financial statements derived from the audited financial statements of Canadian Patient Safety Institute for the year ended March 31, 2016 are a fair summary of those financial statements, on the basis described in the notes to the summarized financial statements.

Chartered Professional Accountants, Chartered Accountants

July 22, 2016
## Summarized statement of financial position as at March 31, 2016

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>1,663,239</td>
<td>1,709,213</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>73,051</td>
<td>130,338</td>
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<tr>
<td>Inventory</td>
<td>–</td>
<td>6,478</td>
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<tr>
<td>Prepaid expenses</td>
<td>159,081</td>
<td>87,319</td>
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<tr>
<td></td>
<td><strong>1,895,371</strong></td>
<td><strong>1,933,348</strong></td>
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<tr>
<td><strong>Capital assets</strong></td>
<td><strong>485,358</strong></td>
<td><strong>89,933</strong></td>
</tr>
<tr>
<td></td>
<td><strong>2,380,729</strong></td>
<td><strong>2,023,281</strong></td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>457,978</td>
<td>600,852</td>
</tr>
<tr>
<td>Deferred government revenue (Note 3)</td>
<td>542,579</td>
<td>528,663</td>
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<tr>
<td>Deferred revenue</td>
<td>79,779</td>
<td>41,614</td>
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<tr>
<td>Deferred rent allowance</td>
<td>37,706</td>
<td>–</td>
</tr>
<tr>
<td>Deferred lease allowance</td>
<td>286,011</td>
<td>7,890</td>
</tr>
<tr>
<td></td>
<td><strong>1,404,053</strong></td>
<td><strong>1,179,019</strong></td>
</tr>
<tr>
<td><strong>Net assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invested in capital assets</td>
<td>199,347</td>
<td>89,933</td>
</tr>
<tr>
<td>Unrestricted assets</td>
<td>362,082</td>
<td>360,672</td>
</tr>
<tr>
<td>Internally restricted net assets</td>
<td>415,247</td>
<td>393,657</td>
</tr>
<tr>
<td></td>
<td><strong>976,676</strong></td>
<td><strong>844,262</strong></td>
</tr>
<tr>
<td></td>
<td><strong>2,380,729</strong></td>
<td><strong>2,023,281</strong></td>
</tr>
</tbody>
</table>
### Summarized statement of operations
**year ended March 31, 2016**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions from Government of Canada (Note 3)</td>
<td>7,586,084</td>
<td>7,608,303</td>
</tr>
<tr>
<td>Registration, sponsorships and product sales</td>
<td>205,472</td>
<td>588,304</td>
</tr>
<tr>
<td>Other revenues</td>
<td>18,040</td>
<td>25,205</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td>7,809,596</td>
<td>8,221,812</td>
</tr>
<tr>
<td><strong>Program expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Improvement and Innovation</td>
<td>966,259</td>
<td>733,311</td>
</tr>
<tr>
<td>Strategic Communications</td>
<td>818,215</td>
<td>939,842</td>
</tr>
<tr>
<td>National Integrated Patient Safety Strategy</td>
<td>400,496</td>
<td>490,520</td>
</tr>
<tr>
<td>Capacity Building &amp; Knowledge Translation</td>
<td>390,947</td>
<td>523,647</td>
</tr>
<tr>
<td><strong>Total program expenses</strong></td>
<td>2,575,917</td>
<td>2,687,320</td>
</tr>
<tr>
<td><strong>Operations expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, wages and benefits</td>
<td>3,607,073</td>
<td>3,652,470</td>
</tr>
<tr>
<td>Other operating costs</td>
<td>948,499</td>
<td>1,210,503</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>155,149</td>
<td>162,364</td>
</tr>
<tr>
<td>Professional services</td>
<td>130,278</td>
<td>341,994</td>
</tr>
<tr>
<td>Travel and meetings</td>
<td>127,743</td>
<td>131,275</td>
</tr>
<tr>
<td>Depreciation</td>
<td>118,292</td>
<td>173,128</td>
</tr>
<tr>
<td>Loss (gain) on disposal of assets</td>
<td>14,231</td>
<td>(908)</td>
</tr>
<tr>
<td><strong>Total operations expenses</strong></td>
<td>5,101,265</td>
<td>5,670,826</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>7,677,182</td>
<td>8,358,146</td>
</tr>
<tr>
<td><strong>Excess (deficiency) of revenue over expenses</strong></td>
<td>132,414</td>
<td>(136,334)</td>
</tr>
</tbody>
</table>
Notes to the summarized financial statements  
March 31, 2016

1. Purpose of organization

The Canadian Patient Safety Institute (the “Institute”) was incorporated under the Canada Corporations Act on December 5, 2003, and effective October 1, 2014, continued under the Canada Not-for-Profit Corporations Act. The purpose of the Institute is to address patient safety issues by strengthening system coordination, promoting best practices and providing advice to governments and stakeholders that places patient safety in the broader context of quality improvement in healthcare.

The Institute is exempt from income taxes under Section 149(1)(1) of the Income Tax Act.

2. Basis of presentation

The summarized financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. The statement of changes in net assets, statement of cash flow and certain note disclosures have been omitted. Reading the summarized financial statements, therefore, is not a substitute for reading the audited financial statements of the Institute.

The Institute is committed to full accountability and transparency in all we do. Our audited financial statements for the year ended March 31, 2016, including all disclosures required by Canadian accounting standards for not-for-profit organizations, can be found on the Institute’s website at www.patientsafetyinstitute.ca.

3. Contributions from Government of Canada

Funding received for the 2015-2016 fiscal year was the third under a five-year contribution agreement with the Government of Canada that provides for total contributions of up to $38,160,000 for the 2014-2018 fiscal years. During the year, the Institute received payments of $7,600,000 (2015 - $7,600,000) from the Government of Canada.

The contribution agreement specifies that the funding must be used for the eligible expenditures under the contribution agreement, or returned to the Government of Canada. Eligible expenditures are determined on a capital expenditure basis. Where funds received in a given year are not fully expended on eligible expenditures, the agreement permits that up to 10% of the current year’s funding can be carried forward to the following year. Of the $7,600,000 in funds received in the year plus the $528,663 carried forward from the 2014-2015 year, the Institute recognized $7,586,084 as revenue, and is holding the remaining $542,579 as deferred revenue to be applied in the 2016-2017 fiscal year. The Institute’s excess of revenue over eligible expenses for Government of Canada purposes was $23,000, as reflected in the increase in net assets other than those invested in capital.

<table>
<thead>
<tr>
<th>Adjustment to capital expenditure basis:</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess (deficiency) of revenue over expenses</td>
<td>$132,414</td>
<td>($136,334)</td>
</tr>
<tr>
<td>Add back depreciation</td>
<td>$118,292</td>
<td>$173,128</td>
</tr>
<tr>
<td>Deduct capital expenditures</td>
<td>($528,044)</td>
<td>($36,841)</td>
</tr>
<tr>
<td>Reverse amortization of leasehold allowance</td>
<td>$61,689</td>
<td>–</td>
</tr>
<tr>
<td>Add leasehold allowance received</td>
<td>$347,700</td>
<td>–</td>
</tr>
<tr>
<td>Add proceeds on disposal of assets</td>
<td>$96</td>
<td>$951</td>
</tr>
<tr>
<td>Reverse loss (gain) on disposal of assets</td>
<td>$14,231</td>
<td>($908)</td>
</tr>
<tr>
<td>Net result reported to Government of Canada</td>
<td>$23,000</td>
<td>$(4)</td>
</tr>
</tbody>
</table>

The Institute’s ability to continue operations depends on the Government of Canada providing on-going contributions in accordance with the contribution agreement.
Salary Disclosure

<table>
<thead>
<tr>
<th>Position</th>
<th>Minimum</th>
<th>Midpoint</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>$252,000</td>
<td>$280,000</td>
<td>$308,000</td>
</tr>
<tr>
<td>Director (Programs, Communications, Corporate Services)</td>
<td>$115,200</td>
<td>$128,000</td>
<td>$140,800</td>
</tr>
<tr>
<td>IT Manager</td>
<td>$85,500</td>
<td>$95,000</td>
<td>$114,000</td>
</tr>
<tr>
<td>Safety Improvement Lead / Manager (Evaluation, Government Relations)</td>
<td>$79,200</td>
<td>$88,000</td>
<td>$105,600</td>
</tr>
<tr>
<td>Marketing and Social Media Manager / Sr. Accountant</td>
<td>$63,000</td>
<td>$70,000</td>
<td>$84,000</td>
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<tr>
<td>Executive Assistant</td>
<td>$58,500</td>
<td>$65,000</td>
<td>$78,000</td>
</tr>
<tr>
<td>Communications Officer</td>
<td>$54,000</td>
<td>$60,000</td>
<td>$72,000</td>
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<tr>
<td>Project Coordinator</td>
<td>$50,400</td>
<td>$56,000</td>
<td>$67,200</td>
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<tr>
<td>Accounting Officer</td>
<td>$47,700</td>
<td>$53,000</td>
<td>$63,600</td>
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</tbody>
</table>
### Performance Measurement Framework with Baselines & Targets

<table>
<thead>
<tr>
<th>Box 1: Education [Output]</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
<th>2015-16</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Learning Sessions Delivered</td>
<td>a) Count of learning sessions* delivered independently by CPSI during the reporting period.</td>
<td>41</td>
<td>57</td>
<td>95</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Count of learning sessions* delivered collaboratively by CPSI and a partner organization during the reporting period.</td>
<td>a)13</td>
<td>a)11</td>
<td>a)18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Count of learning sessions*, containing CPSI content, delivered independently through the HUB model during the reporting period.</td>
<td>c)0</td>
<td>c)7</td>
<td>c)16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*learning session = any CPSI hosted session that: a) involves a teaching component on how to use a tool, resource or patient safety curricula; and b) is not an information or consultation call.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 2: Research [Output]</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
<th>2015-16</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Research Reports Published</td>
<td>Count of research-related reports, both &quot;plain language&quot; and technical, produced by CPSI*, during the period.</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Produced by CPSI would include research activity: a) directly funded by CPSI (in whole or in part), or b) utilizing CPSI human resource time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Box 3: Tools &amp; Resources [Output]</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
<th>2015-16</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Resources Developed &amp; Revised</td>
<td>a) Count of CPSI resources* that were developed during the period.</td>
<td>27</td>
<td>59</td>
<td>56</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Count of CPSI resources* that existed prior to the current period and were revised or updated during the current period.</td>
<td>a)23</td>
<td>b)35</td>
<td>a)21</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Output/Outcome

### Box 3: Tools & Resources (Output)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>Resources Downloaded</td>
<td>Count of downloads of CPSI resources* from the following CPSI owned websites during the period: CPSI, Global Patient Safety Alerts, Safer Healthcare Now!, Patients for Patient Safety Canada, Hand Hygiene, Communities of Practice, Improving Care Search Centre. Calculated by summing page hits for URLs ending in &quot;.pdf&quot; (French and English).</td>
<td>N/A</td>
<td>25,804</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*CPSI resources as defined in 3.1.

Our data collection mechanism was changed in 2015-16 with the introduction of our new website, which made the targets inapplicable. New targets will be set annually during operational planning until the conclusion of the current business plan.

### Box 4: Interventions & Programs (Output)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Safer Healthcare Now! Enrollment</td>
<td>Count of all organizations formally enrolled* in Safer Healthcare Now! through Patient Safety Metrics as of the end of the reporting period. *Formally Enrolled organizations are those that have completed the formal registration process, which requires a signature from the organization’s CEO.</td>
<td>756</td>
<td>1,286</td>
<td>1,100</td>
</tr>
<tr>
<td>4.2</td>
<td>Canadian Patient Safety Week</td>
<td>Count of all registrations for Canadian Patient Safety Week submitted through E-Registration.</td>
<td>1,766</td>
<td>1,178</td>
<td>1,800</td>
</tr>
<tr>
<td>4.3</td>
<td>Canada’s Virtual Forum Participation</td>
<td>Average daily participation (virtual participants + in-person participants) in Canada’s Virtual Forum. Denominator = Number of days in the Virtual Forum. Numerator = Count of virtual and in-person participants in Canada’s Virtual Forum.</td>
<td>857</td>
<td>1,722</td>
<td>1,600</td>
</tr>
</tbody>
</table>

### Box 5: Growing evidence base to improve patient safety (Short-term Outcome)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline</th>
<th>Status</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Promising Practices Deployed</td>
<td>Count of promising practices* in the CPSI Innovation Pipeline that were deployed* during the period. *Promising practice = a process or product identified through routine environmental scanning that: a) has yielded quantifiable improvement to care at a small scale; b) is aligned with at least one of our clinical focus areas; and c) is aligned with improvement work and/or policy positions of thought-leaders in the field.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5.2</td>
<td>Resources - External Faculty</td>
<td>a) Count of all external faculty available to be consulted, as necessary, on the development of CPSI resources. b) Count of all external faculty available to contribute, as necessary, to the delivery of CPSI content to customers. Methodology for collecting this indicaor was adjusted during 2015-16, so the original 2015-16 target no longer applies.</td>
<td>86</td>
<td>90</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Engaged in Development or Delivery</td>
<td>a) 36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) 50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Resources - Patients / Family</td>
<td>Percentage of CPSI initiatives / resources that included a patient or family advisor. Denominator = Count of resources developed or initiatives undertaken during the period. Numerator = Count of CPSI initiatives / resources that, during their life cycle, included a patient or family member.</td>
<td>78%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Advisors Engaged in CPSI Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output/Outcome</td>
<td>#</td>
<td>Name</td>
<td>Definition</td>
<td>Baseline</td>
<td>Status</td>
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<td></td>
<td></td>
<td></td>
<td>2012-13</td>
<td>2015-16</td>
</tr>
<tr>
<td>Box 6: Evidence-informed patient safety culture curricula across health disciplines (Short-term Outcome)</td>
<td>6.1</td>
<td>Learning Modules Created or Revised</td>
<td>Count of all CPSI learning modules that were newly created, and all previously-existing modules that were revised, during the period.</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>6.2a</td>
<td>Academic Faculty Development Learning Sessions - Participating Organizations</td>
<td>Count of academic institutions that were represented at all CPSI hosted academic faculty development sessions.</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>6.2b</td>
<td>Academic Faculty Development Learning Sessions - Participating Individuals</td>
<td>Count of academic faculty [individuals] that were represented at all CPSI hosted academic faculty development sessions.</td>
<td>–</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>6.3</td>
<td>Curricula Mappings Completed</td>
<td>Count of curricula mappings completed during the period.</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>6.4</td>
<td>National Education Network Participation</td>
<td>Count of academics and clinical educators participating as members of the National Education Network as of the end of the reporting period.</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>Box 7: Increased patient safety: a) awareness; and b) knowledge (Short-term Outcome)</td>
<td>7.1</td>
<td>Customers</td>
<td>Count of email addresses present in the Stakeholder Engagement System as of the end of the reporting period.</td>
<td>11,259</td>
<td>10,621</td>
</tr>
</tbody>
</table>
|               | 7.2 | Website Visits & Social Media Interactions                           | a) Count of visits to the following websites: CPSI, Global Patient Safety Alerts, Safer Healthcare Now!, Patients for Patient Safety Canada, Hand Hygiene, Communities of Practice, Improving Care Search Centre.  
  b) Facebook “Talking About Us”* + Twitter clicks + Twitter Re-tweets + YouTube views, likes, comments and shares + SlideShare views, likes, comments, shares, downloads + LinkedIn Engagement**  
  *“Talking About Us” = unique people who have created a story about our page [a like, comment, share, answer, event response, mention, tag, place recommendation].  
  **LinkedIn Engagement = liked + clicked + commented or shared | a) 252,130  
  b) 52,651 | a) 252,534  
  b) 97,976 | a) 344,400  
  b) 72,000 | a) 344,000  
  b) 72,000 |
<p>|               | 7.3 | Increase in Knowledge Following Learning Session - Pre-post measurement of knowledge acquisition | Average increase in pre-post assessment per learning module using pre-post question bank or self-report on individual module content areas.                                                               | 13%      | 11%     | 14%     | 15%     |</p>
<table>
<thead>
<tr>
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<th>Status 2015-16</th>
<th>Target 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Box 7: Increased patient safety: a) awareness; and b) knowledge [Short-term Outcome]</td>
<td>7.4</td>
<td>Increase in Knowledge Following Learning Session - Self-report on overall program learning objectives</td>
<td>Percentage of participants in CPSI learning sessions who report an increase in patient safety awareness and/or knowledge as a result of participating in a CPSI learning session. Denominator = Count of respondents to the question related to awareness / knowledge increase. Numerator = Count of respondents to the question related to awareness / knowledge increase who indicated that they experienced an increase.</td>
<td>86%</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Box 8: Strengthened system coordination related to patient safety [Short-term Outcome]</td>
<td>8.1</td>
<td>National Patient Safety Consortium - Organizations Involved</td>
<td>Count of discrete organizations that attend at least one the following meetings annually: Consortium, four clinical priority summits, Patient Safety Education Network.</td>
<td>0</td>
<td>107</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>8.2</td>
<td>National Patient Safety Consortium - Patients / Family Advisors Involved</td>
<td>Count of patients / family advisors that attend at least one the following meetings annually: Consortium, four clinical priority summits, Patient Safety Education Network.</td>
<td>0</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>8.4</td>
<td>Collaborations with Governments</td>
<td>Count of active formal contracts or agreements* between CPSI and an F/P/T government at the end of the period. *Active contract / agreement = a contract or memorandum of understanding that is active at the end of the current period (either: a) not time-limited; or b) if time-limited, will not expire prior to the end of the period).</td>
<td>6</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>8.5</td>
<td>Collaborations with National / Provincial Institutions &amp; Operational Organizations</td>
<td>“Count of active formal contracts or agreements* between CPSI and: a) national health care / quality / safety institutions; b) provincial health care / quality / safety institutions; and c) health operations organizations**. *Active contract / agreement = a contract or memorandum of understanding that is active at the end of the current period (either: a) not time-limited; or b) if time-limited, will not expire prior to the end of the period). **Health operations organizations include Regional Health Authorities, hospitals, provincial provider governance bodies (like Alberta Health Services), etc.”</td>
<td>17</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>8.6</td>
<td>Learning Sessions - Collaborating Partner Organizations</td>
<td>Count of organizations with active agreements to independently deliver CPSI curricula (HUB) as of the end of the period.</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Output/Outcome</td>
<td>#</td>
<td>Name</td>
<td>Definition</td>
<td>Baseline 2012-13</td>
<td>Status 2015-16</td>
<td>Target 2015-16</td>
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</tr>
<tr>
<td>Box 9: Increase in positive patient safety culture</td>
<td>9.1</td>
<td>TBD - Safety Culture</td>
<td>To be introduced during 2016-17.</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

Box 10: Increase in positive patient safety practices (Intermediate Outcome)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline 2012-13</th>
<th>Status 2015-16</th>
<th>Target 2015-16</th>
<th>Target 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Learning Sessions - Practices Incorporated</td>
<td>Percentage of organizations sampled who report that they have incorporated a practice and/or used tools and curricula they were introduced to during a CPSI learning session. Denominator = Count of organizations sampled. Numerator = Count of organizations sampled who report they have incorporated a practice or used tools and curricula to which they were introduced during a CPSI session.</td>
<td>74%</td>
<td>73%</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>10.2</td>
<td>Patient Safety Metrics - Teams Reaching Goal within 24 Months</td>
<td>Percentage of teams across all interventions that met and maintained their goal within 24 months of their first submission. Denominator = Count of teams that meet the following criteria: a) began submitting to Patient Safety Metrics within the last 24 months; and b) submitted more than 2 data points. Numerator = Count of teams that met the denominator inclusion criteria and also: a) met their target within 24 months of first data submission; and b) held their target for 3 consecutive data points within a 6 month time span.</td>
<td>17%</td>
<td>17%</td>
<td>10%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Box 11: Patient safety is formally: a) monitored; and b) reported (Intermediate Outcome)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Definition</th>
<th>Baseline 2012-13</th>
<th>Status 2015-16</th>
<th>Target 2015-16</th>
<th>Target 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Patient Safety Metrics Utilization Agreements</td>
<td>Count of CPSI’s active formal agreements or shared workplans with: a) health governance organizations; b) health services delivery organizations*; and/or c) researchers, in which the external party agrees to report through Patient Safety Metrics using a customized approach developed by CPSI to meet the external party’s needs. *Health governance and health service delivery organizations include F/P/T governments, Regional Health Authorities, provincial health authorities (i.e., AHS) and self-governed facilities. This indicator excludes service department or team-level agreements.</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>11.2</td>
<td>Patient Safety Metrics - Organizations Actively Submitting Data</td>
<td>Count of discrete organizations who submitted at least one worksheet to Patient Safety Metrics during the reporting period.</td>
<td>275</td>
<td>535</td>
<td>390</td>
<td>345</td>
</tr>
<tr>
<td>11.3</td>
<td>Patient Safety Metrics Worksheets Submitted</td>
<td>Count of distinct worksheets submitted to Patient Safety Metrics during the reporting period.</td>
<td>2,311</td>
<td>19,353</td>
<td>3,800</td>
<td>2,800</td>
</tr>
</tbody>
</table>
### PERFORMANCE MEASURES

**Canadian Patient Safety Institute**

<table>
<thead>
<tr>
<th>Output/Outcome</th>
<th>#</th>
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</tr>
</thead>
</table>
|                |     | **Box 11:** Patient safety is formally: a) monitored; and b) reported (Intermediate Outcome) | 11.4 Global Patient Safety Alerts - Contributing Organizations  
Count of all Global Patient Safety Alerts (GPSA) contributing organizations* as of the end of the current reporting period.  
*Contributing organizations are those organizations that have agreed to have their alerts linked on the GPSA website, not just those organizations that posted alerts during the period. | 24 Total 3 Canadian | 31 Total 5 Canadian | 28 Total 7 Canadian | 34 Total 13 Canadian |
|                |     | **Box 12:** Policies, standards, and requirements of strategic partners are informed by patient safety evidence (Intermediate Outcome) | 12.1 TBD - CPSI Contribution to Accreditation Canada Required Organizational Practices  
To be introduced during 2016-17. | TBD | TBD | TBD | TBD |
|                |     |                                                                      | 12.2 Influence on Professional Standards & Competencies  
a) Engagements - participation on / presentations to bodies mandated to develop standards and competencies  
b) Standards Newly Embedded - new instances of embedment of patient safety standards into standards or competencies  
This indicator was newly introduced during 2015-16. Targets will be set on an annual basis until the conclusion of the current business plan. | TBD | a) 5 b) 0 | N/A | TBD |
|                |     | **Box 13:** Patient safety in Canada is improved (Long-term Outcome) | 13.1 TBD - Outcome measurement through National Patient Safety Consortium  
To be introduced during 2016-17. | TBD | TBD | TBD | TBD |
Our successes are greatest where our partners make care safer.

We thank you.

Canadian Patient Safety Institute

Canadian Patient Safety Institute
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(Back row, left to right): Ronald Guse, Marcel Saulnier, Linda Mattern (past member), Suzanne Bisaillon, Louise Simard, Jean Cox (past member), Doug Hughes and Richard Wedge

(Front row, left to right): Emily Musing (Secretary), Catherine Gaulton (Past Chair), Susan Mumme (Board Chair), Chris Power (CEO), Brian Wheelock (Vice-Chair), and Jillian Paul

Missing from the photo: Vickie Kaminski, Paddy Meade, Donna Murnaghan, and Mark Wyatt
The Canadian Patient Safety Institute would like to acknowledge funding support from Health Canada.
The views expressed here do not necessarily represent the views of Health Canada.

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