Independent Evaluation of the Canadian Patient Safety Institute (CPSI)

Executive Summary

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Executive Summary

The Canadian Patient Safety Institute (CPSI) is a not-for-profit organization funded by Health Canada with a mission to "inspire extraordinary improvement in patient safety and quality" (CPSI, 2015a). Since it was established in December 2003, CPSI has worked in collaboration with stakeholders across the health system to promote patient safety in Canada. Its activities include knowledge generation, synthesis, and translation; competence-building; cultivation and strengthening of relationships with stakeholders across the health system; and leveraging the work of other organizations to optimize the use of scarce resources in promoting patient safety in Canada.

CPSI contracted PRA Inc., an independent evaluation firm, to conduct an evaluation of activities carried out under its current Contribution Agreement with Health Canada, which covers the period from 2013–14 to 2017–18. The evaluation addressed issues and questions relating to the relevance and continued need for CPSI as a third-party national organization dedicated to improving patient safety in Canada; its effectiveness at achieving its objectives and expected outcomes; and the efficiency and economy with which it operates. Although the evaluation focussed primarily on activities under the current Contribution Agreement, it also examined progress toward outcomes associated with activities undertaken prior to March 31, 2013.

The evaluation used multiple lines of evidence, including literature review, document review, review of administrative and performance measurement data, key informant interviews, a survey of CPSI stakeholders, and three in-depth case studies.

Findings

Relevance

This evaluation confirmed an ongoing need to address patient safety in Canada. Recent reports of progress in patient safety in Canada, the US, and the UK concluded that their respective systems have not appreciably moved the mark in patient safety, due not to lack of effort, but to the complexity of the problem.

Persistent rates of harm justify an ongoing focus on patient safety within Canada's healthcare system. As a national organization with a mandate to provide a leadership role in building a culture of patient safety and quality improvement in the Canadian health system, CPSI is well-placed to advocate for the importance of patient safety as a priority within the system. This mandate is bolstered by widespread stakeholder support for the continued existence of a national organization specifically dedicated to patient safety. Indeed, 90% of survey respondents, as well as most key informants, believe there is an ongoing need for such an organization, in order to provide leadership on patient safety and ensure that attention continues to be paid to patient safety within the context of the broader health quality agenda.

While the need for a national patient safety organization clearly remains, it is less clear what should be the role of such an organization in the current environment. Over the past decade, CPSI has fulfilled a critical need in Canadian healthcare by promoting awareness and knowledge of patient safety issues and providing a diverse range of evidence-based tools, resources, and strategies that could be used by healthcare organizations at the clinical and governance levels to address patient safety. The availability of these tools and resources has been particularly important to smaller organizations and jurisdictions with limited resources. Quantitative analysis

undertaken as part of this evaluation suggests that at least some of these tools and resources, such as those associated with *Safer Healthcare Now!* (SHN) have likely generated considerable value-for-money for stakeholders and for the Canadian public at large.

With the proliferation of organizations active in the patient safety field, the maturation and growing internal expertise of Canadian healthcare organizations in patient safety, and the recognition that clinical interventions, while necessary, are insufficient in and of themselves to bring about meaningful improvements in patient safety, the need for an organization to carry out CPSI's historic functions has arguably diminished. CPSI has recognized and responded to these developments in recent years by pursuing a more systems-level and system-based approach to change that focusses on teamwork, culture, and measurement as key elements of safe systems. Indeed, since 2013, and in response to the recommendations of the previous evaluation to focus or rationalize its scope of activity through enhancing engagement with the system and embedding ownership of major programs and activities within system, CPSI has oriented its activities toward achieving system-level change through the pursuit of four strategic goals. Notable initiatives include:

- the recent transition from SHN to SHIFT to Safety, a new initiative that targets new audiences in patient safety, including the public and leaders in a variety of settings, as well as healthcare providers. SHIFT to Safety offers evidence-based resources focussed on improving teamwork, communication, leadership, and patient safety culture and targets the specific needs of its three target audiences.

- the establishment of the National Patient Safety Consortium, with representation from approximately 50 organizations across Canada, and the subsequent development of the Integrated Patient Safety Action Plan (IPSAP). The IPSAP brings together six areas of focus for patient safety into a three-year action plan affirmed by the Consortium, and focusses on collective action toward common goals and priorities as identified by participating stakeholders.

- the development of the Hospital Harm Measure, in collaboration with the Canadian Institute of Health Information (CIHI), which provides, for the first time, a general measure of patient safety in acute care settings in Canada.

The evaluation found that despite these attempts to focus, CPSI's activities and outputs have remained many and diverse. Indeed, throughout the period covered by this evaluation, CPSI has supported the new initiatives described above primarily by scaling back – rather than eliminating – existing program areas and activities. The end result has been that the scope and breadth of CPSI's activity has increased, rather than decreased, since CPSI's last evaluation.

As CPSI representatives acknowledged, since 2013, the organization has had difficulty in balancing its new, more strategic orientation with historical programs that had been successful and that were seen as crucial components of patient safety. They also noted that CPSI's continued broad scope of activity was driven in large part by feedback from the system and a desire to remain responsive and relevant to a diverse range of stakeholders. The diversity of stakeholder needs in relation to patient safety was apparent in this evaluation, with some stakeholders calling for expansion of existing initiatives or investment in new areas where CPSI could focus its efforts or address unmet needs – although it was difficult to find an overarching

theme in their responses. Other stakeholders, however, were concerned that CPSI has had difficulty carving out a unique niche for itself within the patient safety field in Canada. These stakeholders argued that CPSI could have a greater impact on patient safety by more tightly articulating its strategic directions and focussing its efforts and resources on fewer, more narrowly defined priorities and activities.

CPSI representatives characterized the organization as being in a state of transition since the last evaluation, as it has worked towards rationalizing its scope of activity. At the present time in this transition period, CPSI is confronting choices that can be conceptualized as points on a continuum. At one end of the continuum is, essentially, the status quo, and at the other end is a radical rethinking of the organization, with a view to more narrowly defining its mandate, role, and strategic directions; the nature and scope of its activity; and the nature and extent of its partnerships and collaborations. It was beyond the scope of this evaluation, which is first and foremost a retrospective exercise, to determine where on this continuum CPSI should land as it contemplates its future directions. That said, it is clearly not possible for CPSI, as a relatively small organization operating within the very large and multi-faceted healthcare sector, to be "everything to everybody". It seems reasonable, therefore, to repeat the conclusion from the previous evaluation that greater strategic focus is warranted.

Performance – effectiveness

Evidence available to the evaluation indicates that progress has been made toward CPSI's expected immediate and intermediate outcomes.

- CPSI has contributed to an ***increased evidence base to improve patient safety*** primarily by developing tools and resources grounded in national and international research evidence, and stakeholders widely acknowledge and appreciate this work. Some stakeholders argued that CPSI could further contribute to the evidence base through greater emphasis on measurement and rigorous evaluation, including evaluation of its own products and interventions.

- CPSI's work has led to the development of ***evidence-informed patient safety curricula.*** A key success has been the integration of the Safety Competencies into the CanMEDS educational framework of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians in Canada. As part of the IPSAP, work is ongoing with many stakeholders and partners to implement the priorities identified by experts via the Patient Safety Education Action Plan.

- CPSI's work has produced important gains in ***patient safety awareness and knowledge*** among stakeholders. Most survey respondents who have used or implemented specific CPSI programs or resources participated in CPSI education programs, or read CPSI research reports, reported that doing so has led to increased awareness and knowledge of patient safety issues, either their own or within their organization more generally.

- Through spearheading the establishment of National Patient Safety Consortium and the development of the IPSAP, CPSI has ***strengthened system coordination***. These efforts have united a wide range of stakeholders in advancing a common patient safety agenda, while focussing on gaps and avoiding duplication of effort.

- Over the past decade, legislative and policy changes related to patient safety have suggested that Canada has been shifting toward a more ***positive patient safety culture***. Most stakeholders believe this shift has occurred in part because of CPSI's work, although many noted that culture change is a lengthy process, and measurement and attribution are difficult.

- Canadian healthcare organizations have implemented ***positive patient safety practices*** as a result of CPSI activities, with an estimated 88% of eligible acute care facilities and 26% of long-term care facilities in Canada having participated in SHN.

- Progress has been made in ***formal monitoring and reporting on patient safety*** in Canada. Many survey respondents reported using CPSI resources such as the Canadian Incident Analysis Framework to make changes to their approach to managing patient safety. The collaborative work of CPSI and CIHI to develop the Hospital Harm Measure is seen as an important step forward.

- There is evidence of ***policies, standards, and requirements of professional associations and accreditation bodies informed by patient safety evidence***. The Safety Competencies and the Canadian Disclosure Guidelines, in particular, have been widely used and adopted, and more than one-third of Accreditation Canada's Required Organizational Practices (ROPs) reference CPSI resources.

- CPSI has been a pioneer in Canada in advocating for and supporting ***patient and family involvement in healthcare improvement*** in Canada and internationally through its support for Patients for Patient Safety Canada (PFPSC) and other patient engagement activities. The extent of patient and family involvement within the healthcare system and the impact of this involvement for patient safety outcomes has not been measured or rigorously evaluated.

In the long term, CPSI's activities are expected to contribute to ***improved patient safety*** in Canada. Although there is no objective evidence that patient safety in Canada has improved since CPSI was established, most stakeholders believe that CPSI's activities have contributed to improved patient safety. Some argued that without CPSI, it is conceivable that patient safety in Canada might have lost ground rather than remaining stable — particularly given a context of continuous technological and medical innovation, along with the increasing complexity of, and growing financial pressures on, the healthcare system.

Performance – economy, efficiency, and value for money

CPSI has operated in an economical manner over the three years covered by the evaluation. It has taken steps to minimize the cost of inputs by eliminating one office and downsizing another; increasing the number of staff working virtually; and managing staff remuneration, among other measures. Although Health Canada's contribution is CPSI's main source of funding and is likely to remain so in the future, CPSI could continue to explore cost recovery and other revenue-raising potential from sources other than Health Canada, and could articulate a comprehensive pricing model for its products and services.

Likewise, CPSI has taken steps to operate efficiently. It has sought to optimize the quantity and quality of its outputs through the use of web-based technology for information dissemination and

stakeholder engagement, and leveraging in-kind contributions from stakeholders and external experts. The latter have been critical to CPSI's ability to undertake its activities and produce high-quality products and services. While some stakeholders identified potential additional areas for future CPSI activity (with little commonality or agreement among them), others raised concern that CPSI is already overextended, given its size, and recommended it focus on fewer, well-defined priorities in order to achieve greater impact. Other key suggestions included more strategic consideration to partnerships and collaborations; an emphasis on defining future directions in patient safety; and greater attention to measurement and evaluation.

External stakeholders perceive CPSI's activities to have generated considerable value-for-money for their own organization and for others. Furthermore, formal, quantitative value-for-money analysis focussing on CPSI's medication reconciliation activities suggests that these have generated value-for-money by producing cost savings well in excess of the expenses required to sustain them. Implementation of medication reconciliation in one acute care facility has generated positive net benefits by averting the loss of patient welfare that accompanies preventable adverse drug events.

To the extent that CPSI's activities have accelerated the uptake of medication reconciliation in Canadian healthcare and ensured implementation in accordance with current best practice, CPSI is likely to have generated additional value-for-money for its stakeholders in terms of improved patient well-being. Assuming that all SHN interventions are designed in accordance with current best practice, it seems reasonable to assume the same is true of CPSI's activities in relation to SHN interventions more generally.

Recommendations

Perhaps the strongest finding from this evaluation is the clear existence of an ongoing need to address patient safety in Canada. Persistent rates of patient harm justify an ongoing focus on patient safety within Canada's healthcare system. As a national organization with a mandate to provide a leadership role in building a culture of patient safety and quality improvement in the Canadian health system, CPSI is well-placed to advocate for the importance of patient safety as a priority within the system. This mandate is bolstered by widespread stakeholder support for the continued existence of national organization specifically dedicated to patient safety, in order to provide leadership on patient safety and ensure that attention continues to be paid to patient safety within the context of the broader health quality agenda.

Recommendation 1: Given CPSI's mandate, the rates of patient harm that persist in Canada, and the perceived need for an ongoing focus on patient safety, CPSI should work to maintain and enhance the profile of patient safety as a priority across the health system.

Over the past decade, CPSI has fulfilled a critical need in Canadian healthcare by promoting awareness and knowledge of patient safety issues and providing a diverse range of evidence-based tools, resources, and strategies to address patient safety. While the need for a national patient safety organization clearly remains, the evolution of the healthcare system and the patient safety field has raised questions about what should be the role of such an organization in the current environment. CPSI's response has been to pursue a more systems-level and system-based approach to change that focusses on teamwork, culture and measurement as key elements of safe systems. Since 2013, and in response to the recommendations of the previous evaluation to focus

or rationalize its scope of activity through enhancing engagement with the system and embedding ownership of major programs and activities within the system, CPSI has oriented its activities toward achieving system-level change through the pursuit of four strategic goals.

Despite these efforts to focus or rationalize, CPSI's current strategic goals are very broad, and its activities and outputs are many and diverse. Indeed, in an effort to remain responsive to stakeholders, CPSI has effectively increased, rather than decreased, the breadth of its programming. At present, the organization is confronting choices that can be conceptualized as points on a continuum. At one end of the continuum is the status quo, and at the other end is a radical rethinking of the organization, with a view to more narrowly defining its mandate, role, and strategic directions; the nature and scope of its activity; and the nature and extent of its partnerships and collaborations. Given CPSI's small size relative to the size of the healthcare sector, it seems reasonable to repeat the conclusion from the previous evaluation that greater strategic focus is warranted.

Recommendation 2: Given the evolution of the patient safety field over the past decade and its small size relative to the healthcare sector at large, and recognizing that the previous evaluation contained a similar recommendation, CPSI should articulate a more focussed role and strategic direction for itself as a pan-Canadian patient safety organization. In defining this new role and strategic direction, CPSI should reflect on how it can best use its resources to contribute to improving patient safety in Canada.

Broadly speaking, CPSI's activities over the past decade have been based on a theory of change that posits that making available programs, resources, tools and educational opportunities will produce changes in patient safety awareness and knowledge, leading to changes in behaviour and practice, and in the long-term, to improved patient safety. It may be tempting to conclude that because patient safety has not improved in Canada despite progress in achieving gains in awareness and other nearer-term outcomes, CPSI's theory of change must be wrong, outdated or insufficient. While CPSI should not rule out this possibility, it may equally be that the theory of change remains valid, and that the apparent discrepancy is due to factors such as the presence of many confounding influences, the long time horizon needed to achieve change at the system level, or inadequate rigour in, or partial measurement of, outcomes.

In light of these considerations, CPSI should contemplate whether improved patient safety is the appropriate outcome for which it should be held to account. Given its small size relative to the healthcare sector at large and the complex, multi-dimensional nature of the concept of patient safety, it would be more appropriate for CPSI to reconceptualize improved patient safety as its ultimate outcome or vision, while articulating and being held accountable for more specific patient safety-related outcomes that are to be achieved as a result of its activities and that contribute to this vision. This adjustment would be fully consistent with the recommendation for CPSI to define for itself a more focused role.

Recommendation 3: Given the complex, multi-dimensional nature of the concept of patient safety, CPSI should reconceptualize improved patient safety as its ultimate outcome or vision, and articulate a set of more specific long-term outcomes contributing to this ultimate vision for which it should be held to account.

As CPSI embarks on strategic planning process to define its future directions, several opportunities emerged from the evaluation findings for CPSI to consider, such as a greater focus on measurement, research, and evaluation to address a significant perceived gap in the field; additional effort on embedding patient safety into curricula across health disciplines, thus building on an area of strength and considerable success for CPSI to date; or adopting a role as visionary or thought leader, and taking on the challenge of defining the future of patient safety in Canada.

These options are by no means exhaustive. Budget imperatives and other considerations will certainly influence, and quite likely constrain, CPSI's choices. But in contemplating its possible future roles and activities – which should, as a point of departure, include critical reflection on its existing ones – it will be essential for CPSI to think through the underlying theory or theories of change. More specifically, CPSI should think through and more clearly articulate how and why each particular activity is expected to lead to specific immediate, intermediate, and longer-term outcomes, and ultimately, how and why it is expected to contribute to the ultimate outcome or vision of improved patient safety. If, through evidence or logic, a causal pathway cannot be established between a given activity and improved patient safety, CPSI should ponder whether the activity is one to which it should devote resources.

Recommendation 4: In contemplating possible future roles and activities, CPSI should reflect on the theory of change underlying each one; that is, the causal pathway that explains how and why a given activity is expected to contribute to the ultimate outcome of improved patient safety. CPSI's strategic choices should be based on, and reflect, one or more fully articulated theories of change, and its logic model should be revised accordingly.

Moving forward, in keeping with current emphases on measurement and evaluation, CPSI should give greater consideration to how it measures and evaluates its own efforts. Many participants in this evaluation observed that CPSI has contributed to the body of knowledge around patient safety, and has helped spread known best practices across the country and internationally. However, a common theme from participants in this evaluation is that CPSI has not placed enough emphasis on evaluation of its own initiatives and investments, or evaluated these with a sufficient degree of rigour to contribute meaningfully to the evidence on "what works" to improve patient safety. Regardless of what strategic direction CPSI ultimately decides to pursue, a greater commitment to measurement and evaluation of its own activities would serve it well.

Recommendation 5: CPSI should strengthen and devote appropriate resources to its performance measurement and evaluation capacity, in order to support ongoing performance measurement and evaluation of its own activities and initiatives and contribute evidence on "what works" to improve patient safety.