ASK. LISTEN. TALK.
OVERVIEW 2013-2014

Safe care ... accepting no less
MOBILE APPLICATION

Catherine Gaulton, Board Chair

The Canadian Patient Safety Institute is working in collaboration with many organizations and individuals to establish a national action plan on patient safety that will provide a framework for identifying priorities and aligning our work for patient safety gains in Canada.

The work to develop the strategy is well underway. A National Patient Safety Consortium was held to bring partners and interested parties together to develop a patient safety action plan, and summits and roundtable discussions are being held to mobilize around common goals and actions.

I encourage you to learn more about this work throughout this overview.

This is a significant anniversary for the Canadian Patient Safety Institute as it celebrates 10 years of building a safer healthcare system for all Canadians. We invite you to join the celebration in October, during Canada’s Forum on Patient Safety and Quality Improvement — CPSI turns 10. You will hear from many of the organization’s founding members, who will be in attendance to mark the occasion. Visit www.asklistentalk.ca to reserve your spot.

This is also a transitional year for the Canadian Patient Safety Institute. My term as Board Chair comes to an end and this fall I will pass the torch to Vice-Chair Susan Mumme. We will bid farewell to several board members who have completed their terms; our gratitude goes to Donna Allen, Heather Davidson, Maura Davies, Sharon Goodwin, David Hill and Kim Poppel for their guidance and invaluable contributions to the Canadian Patient Safety Institute.

Hugh MacLeod has advised the Board that he will retire at the end of the year and a search has begun to secure a new CEO. Hugh has been a solid thought leader for the organization and we will miss his verve and commitment to make a difference in safe care.

I have proudly served on the board of the Canadian Patient Safety Institute for four years and as Chair for the past two years. During that time, I have enjoyed working with Hugh MacLeod and his strong and committed team. It has been an exciting time to lead a national organization and I thank my fellow board members, voting members, and partners for their tremendous support.

The insight we receive from patients and their families, and the contributions of Patients for Patient Safety Canada as champions of the patient’s voice is invaluable. We thank them for their courage and dedication to advance safe care.

Together, we have come a long way in moving the patient safety agenda forward, yet there is still much to do and challenges to overcome to make healthcare safer. Let’s continue to focus on the greater good, learn from one another and partner with each other to achieve our collective goal of system improvement in patient safety.

Hugh MacLeod, CEO

It has been said before, and it can never really be said enough, you all deserve a big, Thank You for all you do each and every day to inspire extraordinary improvement in patient safety and quality.

In our strategic plan we say, "When Our Partners Succeed, We Succeed.” You are the true heroes of patient safety:

• You, the patient and family members of Patients for Patient Safety Canada who remind us who we are here to serve and who provide us hope through your stories;

• You, at the care provider level, who come to work every day to provide safe care to patients, residents and clients; and

• You, at the policy and operational leadership levels, who have worked with us to create a call to action on patient safety.

Together you push personal and organizational boundaries to generate change, and together you dare to transform healthcare system failures into learning opportunities.

The solutions to our patient safety challenges exist within the healthcare system. They exist within healthcare providers and formal and informal leaders including patients, residents and clients. People like you who understand that preventing harm is worth the effort, while acknowledging that patient safety is a habit, rather than an act.

At the Canadian Patient Safety Institute, we have adopted the mantra ASK.LISTEN.TALK. to help frame and create new patient safety conversations:

• ASK ... questions to test the patient safety assumptions held about the current reality

• LISTEN ... to hear, not counter from all involved, including patients, residents, clients and family members

• TALK ... with the first two in play to create patient safety conversations

I would like to thank the board of the Canadian Patient Safety Institute for setting clear policy directions with the four goals and four priority areas discussed in this overview. I also want to acknowledge and thank the passionate and dedicated staff of the Canadian Patient Safety Institute who come to work every day to honour our vision: “Safe healthcare for all Canadians.”

I hope you find the 2013-2014 Overview informative and insightful. I welcome your thoughts and ideas, and invite you to share the work that is happening in your community that is making a difference in safe care by improving practices and experiences at #CelebratingSafeCare. Together we have the ability to improve outcomes for those we are here to serve — patients, residents and clients.

We Thank You!
LEADERSHIP

National Integrated Patient Safety Strategy

In the business plan for 2013-2018, Patient Safety: Forward with Four, the Canadian Patient Safety Institute made a commitment to advance a national action plan to accelerate patient safety improvement in Canada. The commitment focuses on accelerating safety improvements in four initial areas: medication safety, surgical care, infection prevention and control, and home care.

These are not efforts the Canadian Patient Safety Institute can or should do on its own — safety is a collective responsibility, achievable only through collaboration and drawing on the expertise of many organizations and individuals.

In January 2014, the Canadian Patient Safety Institute hosted the first meeting of the National Patient Safety Consortium in Toronto, Ontario to develop and advance the National Integrated Patient Safety Action Plan. More than 35 organizations were represented, including national patient safety and quality organizations, as well as provincial and territorial quality/patient safety councils, government representatives and patient groups.

Four themes were identified, focusing on the patient’s voice, leadership, measurement, and communication. At the request of participants, the Canadian Patient Safety Institute drafted an action plan with specific goals, immediate and intermediate-term actions, deadlines, and suggestions on who might take up each challenge.

Consortium attendees liked the approach, and its promise of driving action, rather than producing another report to sit on a shelf. The same model is being used for the four priority areas (medication safety, surgical care, infection prevention and control, and home care), with the Canadian Patient Safety Institute acting as a facilitator to bring stakeholders together to identify practical action that governments, organizations, professional and patient groups can undertake to drive patient safety forward.

Safe Surgical Care

A surgical care safety summit was held in March 2014, in Toronto, Ontario, to advance a national surgical care safety action plan. More than 30 organizations attended the surgical care safety summit. Representatives from professional associations — representing respiratory therapists, anesthesiologists, operating room nurses, pharmacists, and surgeons; as well as quality councils, provincial ministries, health authorities, and a patients’ group participated in the summit.

The meeting summary and surgical summit report: A Surgical Care Safety Action Plan is organized around the six themes, with partner organizations recommended for each action. The themes include: measurement and analysis, access, best practices, communication and teamwork, quality improvement, and reporting and learning. The report was provided to all summit participants for feedback and has been presented to the Conference of Deputy Ministers to garner their support in initiating implementation of the Surgical Care Safety Action Plan. Leadership for the action plan will be spread across many organizations, with far-reaching calls for participation to be made across Canada.

Home Care Safety

The first of its kind, Safety at Home: A Pan-Canadian Home Care Study was released in June 2013, examining safety in the home care sector and highlighting solutions, tools and resources to advance client safety. The study has generated new knowledge to improve the safety of home care clients and forms the foundation for a home care safety action plan.

Planning began for a home care roundtable to be held in Winnipeg, Manitoba, in June 2014, hosted by the Canadian Patient Safety Institute and the Canadian Home Care Association, to identify and align a vision to advance client safety in home care.

Medication Safety

In partnership with ISMP Canada, planning is underway for a national medication safety summit to be held in Toronto, Ontario, in June 2014, to create the synergy and coordination required to accelerate improvements in safe medication use in Canada.

Infection Prevention and Control

The Canadian Patient Safety Institute and the Public Health Agency of Canada are working together to co-host a National Infection Prevention and Control (IPAC) Summit in November 2014 in Toronto, Ontario, in an effort to advance IPAC practices and reduce healthcare-associated infections.
The Patient’s Voice

Patients and families bring a voice to the table that helps to accelerate patient safety. Partnering with patients is part of everything we do. The Canadian Patient Safety Institute aims to have 100 per cent of its programs developed and delivered in partnership with patients. For example, the patient’s voice has been at the table for the consortium and informed our work in incident management, education sessions, and research.

Through Patients for Patient Safety Canada (PFPSC), a patient-led program of the Canadian Patient Safety Institute, volunteer champions represented the patient’s voice on approximately 100 occasions, including presentations at key healthcare events; advising boards, committees and working groups; and providing input for strategy and policy development and other instances at all system levels.

PFPSC members have dedicated their efforts to improve and position internal processes for sustainability and success. The member recruitment and orientation programs were revised, the internal newsletter streamlined, and the process for matching patient champions with requesting organizations improved. Succession plans for the co-chairs and working group leads were also put in place.

A number of learning events helped PFPSC members to grow as patient champions. A series of webinars, developed and delivered by members for members, was launched with the inaugural session focused on ways to share your story.

A third party evaluator was contracted to conduct an independent impact evaluation of PFPSC. The final report will be released during Canadian Patient Safety Week 2014.

For more information on PFPSC, visit the website www.patientsforpatientsafety.ca

Global Patient Safety Alerts

Global Patient Safety Alerts is a publicly available, innovative resource that provides information to prevent and mitigate patient safety incidents in healthcare organizations. With Global Patient Safety Alerts, contributing organizations share information about actual incidents, what was learned, and what risk mitigation actions and solutions were implemented to reduce and prevent recurrences. To date, the database contains more than 1,100 patient safety alerts and some 5,800 recommendations from 25 contributing organizations in Canada and around the world.

With Global Patient Safety Alerts, sharing and learning without limitations is possible for healthcare providers, healthcare professionals, patients and the public. Download the free app and find alerts, advisories and recommendations at www.globalpatientsafetyalerts.com

INNOVATION

Research

Much of the focus in the past year has been on translating the knowledge from the three-year study entitled Safety at Home: A Pan-Canadian Home Care Safety Study that was published in June 2013. We continue to work closely with the research team and our partner, the Canadian Home Care Association, to make the study findings relevant to various audiences, including family caregivers and clients, home care organizations and policymakers. Several tools and resources are now available on our website, including resource guides for preventing falls and managing caregiver distress, a medication safety brochure and poster, policy briefs on four key recommendations for change, educational webinars, and journal articles. Visit www.patientsafetyinstitute.ca for more information.

Further research has been commissioned for 2014-2015 for a Small Scale Pilot Study for Patient Safety Innovation to look at the safety culture for hand-offs of care between primary and home care. The study will examine the question: What can we learn from the patient/client experience at the primary care/home care interface that will help us improve safety? The successful applicant, Dr. Mark Fleming of Saint Mary’s University in Halifax, along with his team of experts, will explore the patient experience as the motivator for change and will involve clients/patients and family caregivers in all stages of the study.

The Canadian Patient Safety Institute fosters the development of future patient safety researchers by providing up to six studentships per year, each valued at $5,000. In 2014, four graduate students received studentships to support their work. Visit www.patientsafetyinstitute.ca to learn more about the successful applicants and the innovative ways they are contributing to our knowledge about patient safety.

Safer Healthcare Now! Safer healthcare now!

Safer Healthcare Now!, the flagship program of the Canadian Patient Safety Institute, invests in frontline providers and the delivery system to improve the safety of patient care throughout Canada by implementing interventions known to reduce avoidable harm. The Safer Healthcare Now! interventions provide resources and support improvement efforts across the continuum of care. These include:

- Evidence-based practice tools and resources – Getting Started Kits for acute care, long term care, and home care
- Online measurement and data reporting system – through the Patient Safety Metrics database
- Direct frontline support – for clinicians and healthcare providers which includes support from leading content experts across Canada
- Knowledge translation – via National Calls to illustrate uptake of evidence-based practices across all interventions
- Capacity building in quality improvement and patient safety through various learning series and collaboratives

Safer Healthcare Now! products will be aligned with the activities and actions that arise from the medication, surgical, and infection prevention and control safety summits and the national home care roundtable.

Safer Healthcare Now! is well-positioned to support healthcare providers with evidence-based practices and quality improvement strategies. Visit www.saferhealthcarenow.ca for more information on the interventions and to download valuable tools and resources.
Reducing Falls and Injuries from Falls

As the Safer Healthcare Now! falls intervention lead, the Registered Nurses’ Association of Ontario continues to support falls prevention work across the continuum of care. The Canadian Patient Safety Institute supported the development of a Falls Prevention in Home Care Toolkit, arising from the Safety at Home: A Pan-Canadian Home Care Study. Work is underway to develop a falls quality audit tool for Patient Safety Metrics.

Patient Safety Metrics

Patient Safety Metrics is the data collection platform for teams engaged in Safer Healthcare Now! interventions. Patient Safety Metrics allows organizations to track and report more than 100 key process measures aligned with Safer Healthcare Now! interventions, including surgical site infection, central line-associated bloodstream infection, delirium, falls, hand hygiene and medication reconciliation.

To facilitate ease of data collection, the Central Measurement Team introduced quality audit forms for a number of the Safer Healthcare Now! interventions. Completed quality audit forms are automatically populated into the Patient Safety Metrics system to expedite data collection and reporting. Quality audit forms have been implemented for hand hygiene (acute care, home care and long term care), venous thromboembolism (VTE), and medication reconciliation (acute care admission). In the near future, the forms will be implemented for the prevention of surgical site infections. A falls prevention data collection tool is being introduced as part of a pilot study in Alberta, which will be used for a province-wide audit of falls.

In 2013-2014, Patient Safety Metrics supported audits for hand hygiene, VTE and medication reconciliation to accelerate large scale improvement in these interventions.

For more information and to enroll, visit www.patientsafetymetrics.com

CAPABILITY BUILDING

Planning is underway to host a national patient safety education roundtable in 2015. Findings from the safe surgical care, medication safety, infection prevention and control summits and the national home care roundtable will influence the agenda.

Patient Safety Education Program – Canada

The Patient Safety Education Program – Canada (PSEP – Canada) takes an inter-professional team approach to improving patient safety skills, planning patient safety education and aligning with quality improvement initiatives. The program is built on a train-the-trainer approach, providing a peer-to-peer education framework for participants. On completion of the PSEP – Canada two-day program, participants are armed with a full patient safety education curriculum, case-based learning tools and customizable presentations that can be aligned to their local patient safety work. Organizational action planning is also included in the PSEP – Canada program, to equip participants with concrete implementation plans that can be applied in their organizations.

The curriculum will be enhanced next year with the release of three new modules focusing on Medication Reconciliation, Capacity Building and the Canadian Incident Analysis Framework.

A PSEP – Canada conference was hosted in Toronto in collaboration with the Ontario Hospital Association; and an affiliate PSEP – Canada conference was held with the Canadian Forces in March 2014. Through a post-program support initiative, PSEP – Canada trainers are connected, supported and challenged through a growing network of colleagues who are actively engaged in quality and patient safety work across the country. The post-program support activities include several initiatives such as a vibrant web-based Community of Practice, webinars, action learning series and follow-up calls.

In May 2014, the Canadian Patient Safety Institute hosted a PSEP – Canada conference in Sudbury, Ontario, in partnership with the Northern Ontario School of Medicine and the Ontario Hospital Association. A Queen’s University affiliate PSEP – Canada conference will be delivered in August 2014. The fourth annual PSEP – Canada conference in collaboration with the Ontario Hospital Association is scheduled for October 2014 in Toronto. For more information, visit www.patientsafetyinstitute.ca

Canadian Incident Analysis Framework

Everyone, from patients and families to leaders, have a role to play in preventing, managing and learning from incidents to make care safer. Creating an environment that supports a safe and just culture at organizational levels and structures (such as legislation, standards and policies) is vital for maintaining safety and managing incidents.

Using the incident management continuum from the Canadian Incident Analysis Framework as the foundation, and under the guidance of a group of experts (the Incident Management Faculty), four focus group sessions took place to better understand user needs, expectations and best practices. An incident management program will be developed by which all the related components of patient safety incidents will be connected in the incident management continuum and the incident management toolkit [e.g. disclosure, incident analysis, informing the media, supporting healthcare providers]. This will strengthen the ability of those at the frontline of care and professionals responsible for patient safety to address issues at any point.

Ultimately, the program endeavors to reduce patient safety incidents in the system, reduce the likelihood of additional harm, and improve the experience for patients, families and healthcare providers when events do occur.

The Canadian Patient Safety Institute contracted a review of white and grey literature to identify evidence and resources, and is now in the process of synthesizing and translating the findings into the electronic incident management continuum and toolkit. The electronic toolkit will be launched in January 2015.

To learn more and to download the Canadian Incident Analysis Framework, visit www.patientsafetyinstitute.ca
ASPIRE (Advancing Safety for Patients in Residency Education)

ASPIRE is geared towards medical educators who have a demonstrated interest and/or experience in patient safety and quality improvement and in teaching faculty and residents. At the end of the workshop, participants are equipped to serve as instructors, faculty resources and champions for the dissemination of patient safety and quality improvement curricula, aligned with the CanMEDS roles, throughout their postgraduate educational program.

Building on the success of ASPIRE 2013, the Royal College of Physicians and Surgeons of Canada and the Canadian Patient Safety Institute will offer ASPIRE — Phase 2. The 2014 program will align patient safety and quality improvement concepts with the CanMEDS 2015 framework.

For more information, visit www.patientsafetyinstitute.ca

Effective Governance for Quality and Patient Safety

The Effective Governance for Quality and Patient Safety (EGQPS) program offers a unique opportunity to explore evidence-informed approaches to governance and leadership and to share innovative health governance practices, resources and tools. This core program has been offered to and contextualized for partners in acute care, primary care and long-term care.

The Canadian Patient Safety Institute partnered with the Association of Family Health Teams Ontario, Association of Health Centres, Ministry of Health and Long-Term Care, Nurse Practitioners’ Association of Ontario, Manitoba Institute for Patient Safety, and Health Quality Ontario to offer 13 core sessions to more than 400 participants.

The Canadian Patient Safety Institute also worked with the Association of Family Health Teams Ontario to offer a two-day, train-the-trainer workshop on this program. The Association of Family Health Teams Ontario delivered three workshops to a total of 89 participants.

The Canadian Patient Safety Institute is working with the Health Association of Nova Scotia and the Atlantic Health Care Patient Safety Collaborative to deliver an Effective Governance for Quality and Patient Safety train-the-trainer session in Halifax, Nova Scotia, in the fall of 2014.

For more information, visit www.patientsafetyinstitute.ca

Canadian Patient Safety Officer Course

The Canadian Patient Safety Institute and the Canadian Healthcare Association partnered to deliver a Canadian Patient Safety Officer Course in Ottawa, Ontario, in 2013 and 2014. Both events were held over four days, with participants from across Canada and international guests.

The Canadian Patient Safety Institute and the Canadian Healthcare Association have partnered to develop a comprehensive Canadian Patient Safety Officer Online Program (CPSO Online). The program is based on the successful in-person program that has been offered since 2007. CPSO Online is designed for busy patient safety professionals, with flexibility so that participants can learn at their own pace wherever and whenever they choose. The eight on-line module courses include readings, videos, webinars, discussion forums, coaching and a patient safety project. CPSO Online will be pilot tested in July and launched in the fall 2014.

For more information, visit www.patientsafetyinstitute.ca.

Safety Competencies

The Canadian Patient Safety Institute Safety Competencies mapping project, an initiative to map the six domains of the framework to a sample of faculties in medicine, nursing and pharmacy came to a close. During the three-year project, a total of 15 faculties and one medical specialty program mapped knowledge, skills and attitudes contained in the Safety Competencies framework to their curricula. The focus of the project was not only to promote awareness of the safety competencies, but also to encourage faculties in all of the health professions to integrate the framework by using the domains to determine what explicit safety content is included, or where gaps exist in their curricula. In addition, several national organizations responsible for accreditation, certification and regulation of health professionals have had their standards, learning objectives/outcomes or entry-to-practice standards directly mapped to the safety competencies, and the principles of patient safety based on the framework integrated into their documents. To download the Safety Competencies Framework, visit www.patientsafetyinstitute.ca
Improved Patient Safety Practices, Experiences, Outcomes

The Canadian Patient Safety Institute is a not-for-profit organization that exists to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. Funded by Health Canada, the Canadian Patient Safety Institute reflects the desire to close the gap between the healthcare we have and the healthcare we deserve.

Our future is based upon a foundation of collaboration in how we bring alive our role and how we do our work.
STOP! Clean Your Hands Day

For the fifth consecutive year, the Canadian Patient Safety Institute hosted STOP! Clean Your Hands Day in Canada on May 5, 2014 in partnership with Accreditation Canada, Infection Prevention and Control Canada and the Public Health Agency of Canada. This national event was sponsored by GOJO and coincides with the global initiative of the World Health Organization, “Save Lives: Clean Your Hands.”

A record-setting 1,406 sites across Canada participated in STOP! Clean Your Hands Day, the third highest participation rate in the world behind the United States and the Philippines. This year, we provided an electronic toolkit, rather than mailing a package of promotional materials. The highlight of the toolkit was a one-minute promotional video on Your Four Moments of Hand Hygiene. This simple, yet creative video was produced without narration or on-screen text so that it could be viewed and understood by people of any age or any language.

For the second consecutive year, the Canadian Patient Safety Institute held a Dragon’s Den-styled What’s Your Hand In It? contest, where organizations were invited to submit their best ideas for hand hygiene improvement to a panel of judges that included representatives from Accreditation Canada, Patients for Patient Safety Canada and the Canadian Patient Safety Institute. The winner was the Provincial Infection Control Network of British Columbia for their “Clean Shots” photo campaign.

For more information on hand hygiene, visit www.handhygiene.ca

Canada's Forum on Patient Safety and Quality Improvement – CPSI turns 10

The Canadian Patient Safety Institute is turning 10! It is a time to celebrate and an opportunity for everyone to get involved! This year’s Canadian Patient Safety Week engagement campaign will be aimed at “Celebrating Safe Care.” Sharing initiatives from across the country will help to build momentum and bring light to the great work being done in patient safety.

Canada’s Forum on Patient Safety and Quality Improvement will take place in Edmonton, Alberta, October 28 and 29, 2014.

You're invited to join this exciting learning opportunity, to toast our collective efforts to improve patient safety and quality in Canada. For those who can’t be with us in-person, the entire event will be broadcast live on the Internet.

The Canadian Patient Safety Institute will also host a pre-conference event in partnership with Alberta Health Services and the Health Quality Council of Alberta on October 27. Save the dates to ensure you don’t miss the celebration and join us to mark a decade of patient safety and quality improvement.

Register today at www.asklistentalk.ca.

In 2013, 5,840 viewers from 1,913 sites and 15 countries logged on to Canada’s Forum. For those who were unable to watch live, or who want to re-watch or use portions of the broadcast for their own internal educational purposes, the event is archived online at www.asklistentalk.ca

Canadian Patient Safety Week

Canadian Patient Safety Week (CPSW) is a national annual campaign to inspire extraordinary improvement in patient safety and quality improvement. CPSW 2013 reached new heights for participation with 2,175 registrants and the distribution of 1,580 packages of promotional materials focusing on the message of ASK.LISTEN.TALK.

Registration is now open for CPSW 2014 at www.asklistentalk.ca. CPSW is also an opportunity for partners to endorse and celebrate the efforts of others in patient safety.
2013 – 2014 BY THE NUMBERS

• 3,500,000 medication records distributed in Canadian Patient Safety Week packages
• 1,000,000 impressions of #asklistentalk on Twitter
• 760,466 website page views
• 588,517 emails distributed to promote 22 campaigns (average 33 per cent opened and 14 per cent clicked)
• 56,697 social media interactions and 4,685 Twitter followers
• 29,197 YouTube views, totaling 1,073 hours and 13 minutes
• 11,189 downloads of the Canadian Incident Analysis Framework
• 5,840 viewers from 1,913 sites and 15 countries logged-on for Canada’s Forum on Patient Safety and Quality Improvement
• 3,672 Safer Healthcare Now! webinar participants
• 2,300 follow-up views of Canada’s Forum from 873 sites since the live broadcast
• 2,175 organizations participated in Canadian Patient Safety Week (a 23 per cent increase over 2012)
• 2,124 additional downloads of the Safety Competencies Framework; more than 12,000 and counting downloads to date
• 1,703 lines open for MedRec national calls, with 2,518 participants
• 1,580 packages distributed free of charge for Canadian Patient Safety Week, including 30,000 posters, 150,000 Hands in Healthcare magazines, 30,000 tent cards with medication records, 100,000 tattoos, 20,000 Knowledge is the Best Medicine booklets and several thousand one-pagers
• 1,406 sites registered for STOP! Clean Your Hands Day – the third highest participation in the world
• 1,376 healthcare leaders, providers and patients participate in our formal educational offerings
• 962 organizations enrolled in Safer Healthcare Now!
• 300 new alerts and 1,800 new recommendations added to Global Patient Safety Alerts – a valuable resource housing 1,100 alerts and 5,800 recommendations
• 258 faculty providing expert patient safety counsel and advice
• 200 healthcare professionals attend the Atlantic Health Quality and Patient Safety Collaborative to learn from experts and one another
• 118 sites participated in National VTE Audit Day; of 4,667 patient records audited, 81 per cent received appropriate thromboprophylaxis
• 103 sites audit 2,340 patient/resident charts for Canadian MedRec Quality Audit
• 100 process and outcome measures across 14 Safer Healthcare Now! interventions tracked by Patient Safety Metrics
• 84 more trainers certified, joining the cadre of over 300 certified as PSEP – Canada Patient Safety Trainers; with an additional 18 certified through an affiliate arrangement
• 78.3 per cent of healthcare workers who participated in the Canadian Hand Hygiene Audit clean their hands
• 44 participants complete the Canadian Patient Safety Officer Course
• 13 sessions on Effective Governance for Quality and Patient Safety to help healthcare boards implement an evidence-informed approach, with 418 participants; three affiliate sessions delivered to 89 participants
• 6 patients join the 61-member Patients for Patient Safety Canada network; promoted patient’s voice at over 100 events
• 5 new patient videos produced featuring Patients for Patient Safety Canada members
• 4 graduate students awarded studentships

Our successes are greatest where our partners make care safer. We thank you.

To review the Canadian Patient Safety Institute 2013-2014 Financial Statements and Scorecard, visit www.patientsafetyinstitute.ca
We thank you.

Canadian Patient Safety Institute
www.patientsafetyinstitute.ca

Head Office
Suite 1414, 10235 101 Street
Edmonton, AB T5J 3G1
Phone: 780.409.8090 Fax: 780.409.8098
Toll Free: 1.866.421.6933

ISSN: 1920-6100

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.