NATIONAL PATIENT SAFETY CONSORTIUM & LEADS MEETING

October 11-12, 2017

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Foreward by Chris Power

The Canadian Patient Safety Institute will begin implementing a new five-year strategic plan in 2018 which we are calling “Patient Safety Right Now.” It is built around the vision of making Canadian healthcare the safest in the world.

One of the many building blocks of that plan and the advancement of patient safety in Canada is the work of the National Patient Safety Consortium which held its fifth meeting in October in Toronto.

The Consortium and the Integrated Patient Safety Action Plan show what can be done when committed organizations united with dedicated patients work together to tackle patient safety issues.

During the two days of meetings in Toronto there was an opportunity to mark those achievements. The gathering was also an opportunity for participants to express their views on the challenges and opportunities moving forward.

We listened and we heard. And what we heard was strong support for CPSI to move forward and be more focused. Just as a magnifying glass can focus the rays of the sun to ignite a piece of paper, we believe providing more focus to patient safety initiatives can once again ignite the fires that have dimmed in recent times of competing priorities.

We are keen to stay engaged with all organizations involved with the Consortium and the Integrated Patient Safety Action Plan and hear your views on what your organization’s role should be in our new vision of making Canadian healthcare the safest in the world. We want everyone to be involved. Everyone has a role and benefits from improving patient safety.

As Donna Davis from Patients for Patient Safety Canada stated so powerfully in her concluding remarks to the Consortium: “ If CPSI is the guardian of patient safety, we, all of us across the land, are the wards of patient safety because at some point in our lives, or the lives
of our loved ones, we will be impacted by patient safety. We could be one of 1.2 million deaths; one of us could be one of 13 harmed.”

Nothing I could say could state so clearly the compelling case for us to ignite the work of the Consortium and advancing the case for “Patient Safety Right Now.”

To quote Donna once again in closing:

> **“We can’t lose the hope and the trust that we will have the safest healthcare in the world.”**

Executive Summary

It was with a palpable sense of achievement coupled with a recognition of the work yet to do that more than 100 people gathered in Toronto to celebrate the work of the National Patient Safety Consortium.

As a former co-chair of Patients for Patient Safety Canada Donna Davis noted at the end of the meeting "from a few people, a few organizations and a few patients who were aware and passionate about patient safety it (the Consortium) has grown to what you have seen and heard in this room yesterday and today, 270+ people involved in the Consortium, 50+ organizations involved and patients at all the tables."

The power of this partnership to address patient safety issues and the primacy given to patient involvement were two themes that resonated throughout the series of plenary presentations and small-group discussions that made up the meetings.

Over the two days, the attendees reviewed the work achieved by the National Patient Safety Consortium since its formation in 2014 and the development of the Integrated Patient Safety Action Plan. This work included some significant milestones in furthering the enhancement of patient safety in Canada such as:

- Publication and widespread dissemination of The 5 Questions to Ask About Your Medications
- Two STOP Clean Your Hands Day Campaigns
- Never Events for Hospital Care in Canada report
- Engaging Patients in Patient Safety - A Canadian Guide

Equally important was the fact the meetings provided an opportunity for partner organizations and individuals involved with the Consortium to provide constructive feedback on the newly approved five-year strategic plan of the Canadian Patient Safety Institute and suggestions for a potential framework for the Consortium following the conclusion of its currently defined mandate at the end of March 2018. Some focus on this was provided at the meeting with the reporting of preliminary results and recommendations from an extensive evaluation of the Integrated Patient Safety Action Plan and the National Patient Safety Consortium.

The first day of meetings was a gathering of the Leads Groups. On the second day, the Leads Groups members joined the National Patient Safety Consortium. A celebratory evening reception was also held with over 100 attendees.

On the first day of meetings, the five Leads Groups of Surgical Care Safety, Medication Safety, Home Care Safety, Infection Prevention and Control, and Patient Safety Education, had an opportunity to discuss their respective action plans. Many presentations detailed the work done by each group as well as the challenges and opportunities associated with these activities. Leads Group members were also provided with overviews of the evaluation process and findings and the new CPSI strategic plan as well as a primer on how behavioural science can assist in making patient safety initiatives more successful.

Many of those at that meeting also joined the second day's proceedings, which focused on the work of the National Patient Safety Consortium itself with specific updates on achievements to date. Here, keynote speakers also prompted wide-ranging discussions on patient safety issues and many speakers took the opportunities to provide the perspective from the organizations they represented.

While details of many specific initiatives were spotlighted, many common themes emerged from the presentations and numerous small group discussions and question and answer periods built into the program.

These included:

- The fundamental importance and value of involving patients, families and stakeholders in all aspects of the work of the National Patient Safety Consortium and the Integrated Patient Safety Action Plan.
- Widespread support for the National Patient Safety Consortium approach for advancing patient safety in Canada
- Acknowledgement of the need to bring more focus to the work of the National Patient Safety Consortium and support a smaller number of initiatives that can have more impact
- Concern about the ongoing lack of public and patient awareness of patient safety as a significant issue within the Canadian healthcare system.
- The need to better align patient safety initiatives with the priorities and work of provincial and territorial governments

* Quebec did not participate in the Consortium. It is solely responsible for the planning, organization, management and evaluation of patient safety within Quebec.

Those attending the meetings were reminded repeatedly of the challenges in changing the patient safety landscape and taking approaches based on scientific principles.

The second day concluded with an heartfelt presentation from Donna Davis representing Patients for Patient Safety Canada who reinforced the need to make patient safety a core issue and value for the Canadian healthcare system. The meeting evaluations are very strong, as shown in Appendix A.

Leads Group Meetings - Oct. 11, 2017

Introduction

For the second year, a day-long gathering of the five Leads Groups took place that included Surgical Care Safety, Medication Safety, Home Care Safety, Infection Prevention and Control, and Patient Safety Education. Fifty-four individuals participated in meeting (see Appendix B).

CPSI CEO Chris Power welcomed delegates to the day and, as she would also do on day two, started by acknowledging the land on which the meeting was being held. "This meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land." Power talked about the passion, expertise and energy around patient safety of those in the room and said she was "really excited to see where the day will take us."

The meeting objectives for the day were set out as follows:

1. Feel reenergized about your contributions to advancing patient safety across Canada through the Integrated Patient Safety Action Plan
2. Receive a progress update from each area of focus
3. Discuss advancing specific actions from the Integrated Patient Safety Action Plan; and
4. Build new and strengthen existing relationships with individuals from various Leads Groups.

Power then introduced Maura Davies as the facilitator for both days of meetings. Davies is past President and Chief Executive Officer of the Saskatoon Health Region and since 2014 works with organizations and teams to enhance quality, patient safety, governance and patient- and family-centred care. Davies was part of the first meeting when the National Patient Safety Consortium was being created and said she has followed "with enormous interest and respect" the work of the Leads Groups. She said the Leads meeting and the National Patient Safety Consortium meeting to follow "are about keeping people safe." She also noted the importance of patient voices in the deliberations and in grounding the work that was underway.

Linda Hughes, co-chair of Patients for Patient Safety Canada (PFPSC) and a member of the National Patient Safety Consortium Steering Committee gave a brief presentation discussing the role of patients' experiences in the Integrated Patient Safety Action Plan. With the mission of "Every Patient Safe," she said PFPSC has been involved as equal partners in developing the Integrated Patient Safety Action Plan and had nine members present at the Leads meeting. She said patients, families and caregivers who were part of PFPSC felt "overwhelmingly" that they were welcomed and their experiences valued. Quoting patient advisor Maaike Asselbergs, she said "patient involvement was not an abstraction, but a reality" in working on the plan. But Hughes then stated some concerns from PFPSC members that were heard repeatedly throughout the two days of meetings, namely that too many actions had been proposed and that more focus was needed. In summary, she said PFPSC members made the following suggestions to the National Patient Safety Consortium:

> **"How do we take all of this great effort and actually have impact?"**
>
> – Maura Davies

- Continue to involve patients, families and caregivers at all levels of decision making
- Provide support according to each volunteer's unique circumstances
- Focus on fewer priorities. Use our help.
- Implement patient safety improvements which empower patients and families to be true partners
- Evaluate outcomes—let's make care safer!

"You're already starting to challenge us," Davies responded, "and we need to assess not only how far we have come … but also take that feedback to inform the decisions about where to go." She also said patient partners were rightfully applying pressure on the National Patient Safety Consortium to do better "because we're not yet where we need to be".

The Way Forward—CPSI New Strategic Plan

At the Leads meeting and again at the National Patient Safety Consortium meeting the following day, Power discussed the development and details of the new 5-year strategic plan for CPSI that was approved by the Board in September and will be initiated in April 2018. She said Hughes' presentation mirrored some of the feedback CPSI had heard from others over the preceding 18 months about the direction CPSI needs to take in future. Power discussed a recent independent evaluation of CPSI which concluded that CPSI is helping the provinces and territories make advances in patient safety. But she said those providing input also stated "you (CPSI) have done great work but you need to focus." With an annual budget of $7.6 million she said the assessment also concluded that CPSI was providing good value for money but can't be all things to all people. "We still need to have a federal organization focused on patient safety," she said the evaluation found, and there was lots of support for CPSI continuing to play this role.

Power was forthright in stating the need for CPSI to take a different approach to deal with the ongoing challenges of patient safety. She said the new strategy is being called "*Patient Safety Right Now*" because "enough is enough. We still harm people at an alarming rate in this country." Work commissioned for CPSI by RiskAnalytica Canada shows that unless there are changes in how patient safety is approached someone will die from a patient safety incident every 13 minutes by 2030 instead of the estimated every 17 minutes currently. "We need to draw a line in the sand and say things need to change right now," Power said. As such, the new CPSI strategic plan sets a bold direction with new vision and mission statements to improve on Canada's position as being the ninth safest country among ten Organisation for Economic Co-operation and Development (OECD) nations for healthcare quality. "We can absolutely do this and hold our heads high and say we have the safest healthcare in the world," said Power. This will be based on advancing the culture of sustained improvement in patient safety, she said and "it's about demonstrating what works and strengthening commitment." Power also discussed at length the various strategies planned by CPSI to achieve this.

Outcomes of the Integrated Patient Safety Action Plan

Members of the Five Lead Groups met separately to review and discuss the action plan progress, and reflect on what has been accomplished in their respective area of focus, and of what they were most proud. Groups were also asked to talk about the challenges they had faced and will face in future, and try to anticipate what the future will look like in their areas. Davies stressed the presentations were an opportunity to celebrate the work achieved to date.

Summaries of these discussions were then incorporated into rapid-fire presentations which were repeated in a more condensed form on the following day. At the full National Patient Safety Consortium meeting, Davies described the Leads Groups as the "boots on the ground" working to implement the Integrated Patient Safety Action Plan as well as noting commonalities among the work of the five groups. Summaries of some of the findings from each of the five groups are as follows:

Surgical Care Safety, Brian Penner (Patients for Patient Safety Canada)

- 33% of work completed
- 50% of work underway
- 17% of work scheduled to start later

Accomplishments to date:

- A retrospective review and publication of a report regarding surgical incidents
- Published a report detailing tools and resources to support proactive analyses in surgical care safety
- The identification of 8 national surgical safety indicators
- The identification of ERAS (Enhanced Recovery After Surgery) best practices as those to spread across the country through Enhanced Recovery Canada (ERC)

What we are most proud of:

- Active collaboration between surgeons, patients, nurses and others working together. Good to see everyone at the same table
- Understanding the importance of adverse events in surgery and how we can address them
- Reached a national consensus re: ERAS as surgical best practices. We have a solution and a path supported with industry sponsorship of $500,000

Medication Safety, Sylvia Hyland (ISMP Canada)

- 80% of work completed
- 20% of work scheduled to start later

Accomplishments to date:

- 5 Questions to Ask About Your Medications
- Medication Incident Reporting in Canada: A White Paper
- MedSafety Exchange Webinar Series
- Opioid Pain Medicines Information for Patients and Families
- Guidelines for Safe Storage and Disposal of Opioids (coming soon)

What we are most proud of:

- Partnership with patients and families
- Customization of 5 Questions to Ask About Your Medications into more than 20 different languages, ability to incorporate sponsor logos into materials and endorsement of the tool by more than 100 sponsors.

Infection Control and Prevention, Gerry Hansen (IPAC Canada)

- 36% of work completed
- 36% of work started
- 27% of work scheduled to start later

Accomplishments to date:

- Conducted an environmental scan of infection prevention and control and behaviour change.
- Held STOP Clean Your Hands Day Campaigns (2016 and 2017).
- Conducted an annual innovation competition to drive frontline engagement and improvement in infection control.
- Reviewed current CNISP (Canadian Nosocomial Infection Surveillance Program) definitions and identified barriers and challenges to utilization at smaller, non-CNISP hospitals.
- Exploring opportunities with CNISP and CIHI (Canadian Institute of Health Information) to collect, analyze and report pan-Canadian healthcare associated infections surveillance data.

What we are most proud of:

- Great support from partners and participants for STOP! Clean Your Hands Day 2016 and 2017.
- Recruiting 40 expert and engaged faculty who have created a dynamic workplan to spread knowledge through implementation science
- The process of developing standard long-term care case definitions and review of current CNISP acute care definitions resulted in consensus amongst the various working groups.
- Defining an unperceived need and uncovering potential opportunities for the way forward through partnerships and collaboration.
- Reviewed current CNISP definitions and identified barriers and challenges to utilization at smaller, non-CNISP hospitals

Home Care Safety, Helene LaCroix (Saint Elizabeth)

- 52% of work completed
- 24% of work started
- 24% of work scheduled to begin later

Accomplishments to date:

- Broadened thinking on patient safety in the home care field—differences in the home care setting
- Deepened and broader participation of patients in home care national patient safety work
- Pan Canadian approach to teaching Quality Improvement (QI) Methodology and implementing and evaluating use of evidence-based practices in home care (Collaboratives Wave I and II)

What we are most proud of:

- Creating foundation for learning from each other on data
- Engaging and embedding the patient voice in the work of the Home Care Action Plan
- Realizing safety in the home environment is very dependent on relationship and conversations—different from acute care. Patients in home care tend to engage in home care over long periods of time and needs change over time, so conversations on safety need to change and evolve.
- Pan Canadian Expert Faculty

Patient Safety Education, Tim Willet (SIM-one Canada)

- 33% of work completed
- 33% of work started
- 17% of work scheduled to start later
- 17% expected to start but delayed

Accomplishments to date:

- Development of Leadership Bundle of knowledge

and skills for healthcare leaders on patient safety

- Ongoing development of a Patient Safety and Quality Improvement taxonomy

What we are most proud of:

- A very committed team for 3 years
- Different people with different perspectives
  - Common ground
  - Common understanding of issues and scope
  - Conceptualized the breadth and depth of the issues and needs
  - Leveraged 'bundle' trend for leaders

National Patient Safety Consortium Preliminary Evaluation Results

Dr. San Ng, managing director and Jean Trimnell, management consultant from Vision & Results Inc. discussed preliminary results of the evaluation of the National Patient Safety Consortium and Integrated Patient Safety Action Plan. Ng and Trimnell gave a similar presentation to the National Patient Safety Consortium group on the second day.

The evaluation was intended to answer 4 key questions, based on a Collective Impact evaluation model:

1. How do we collaborate?
2. What has been done?
3. How well is it working?
4. Is it making a difference?

Ng noted the findings were based on a robust evaluation methodology including document review, interviews with the National Patient Safety Consortium Steering Committee, focus groups with CPSI staff, Leads groups and Action Teams and an online survey with a 24% response rate (74) responses. Based on the findings, she said, draft recommendations have been developed but not finalized because of the wish to incorporate further feedback.

Overall, the evaluation found a very strong level of collaboration within the National Patient Safety Consortium. "Every single person talked about the great lengths people had gone to identify partners or work together," Ng said, suggesting this outcome "needs to be recognized, celebrated and spread." The effectiveness of CPSI as a coordinating body was mentioned by many as was the extensive nature of patient involvement during all stages of the development of the action plan. Barriers to collaboration raised most often were limitations in time and resources and challenge of sustaining commitment. Ng said National Patient Safety Consortium members and especially members of the Leads Groups should be very happy with the "tangible outputs of their work."

In terms of the accomplishments of the National Patient Safety Consortium, the evaluation found there was a sense the work had increased health system alignment, commitment, and understanding of priorities for improving patient safety. Five main barriers were referenced concerning implementing the Integrated Patient Safety Action Plan: lack of financial/administrative resources; competing priorities/time; involvement and commitment of organizations to implement; stakeholders—need to add or in some
cases too many; lack of shared measurement.

Of concern was the fact that the evaluation found only a very small proportion of survey participants reported having used the outputs to improve patient safety. In terms of whether the work has made a difference, respondents felt ground breaking work had taken place that might not have occurred if this initiative had not been in place. About half of participants said there has been an impact on the level of commitment to patient safety and ability to improve patient safety and reduce harm. Almost all respondents (95%) said they would recommend the National Patient Safety Consortium approach for improving patient safety.

Following presentation of the results, the Leads participants were asked to identify the top 3 key priorities for their area to achieve impact on patient safety. This resulted in a lively discussion of ways to select priorities for each of the 5 areas. It was noted that each group was attempting in its own way to create a knowledge to action framework and Ng noted sharing learnings would support patient safety across a variety of areas. "What we see here today is a real desire to move forward," Ng concluded. "We don't think the work is done yet and we don't think people will be happy if the work ends March 31." Davies noted there was a sense of pride in achievements to date and an "absolute desire" to keep moving forward with work felt to be on the brink of having an impact.

> **"Each of us are vested in these projects that we've done but what has come out of this today are some clear linkages"**
>
> – Leads participant

Knowledge Translation and Implementation Science Approaches to Patient Safety

Dr. Jeremy Grimshaw, Senior Scientist, Clinical Epidemiology Program, Ottawa Hospital Research Institute and Canada Research Chair in Health Knowledge Transfer and Uptake, gave a presentation on how to better incorporate evidence into practice in the patient safety field, while stressing that he did not have all the answers. "If it was easy we wouldn't be in this room," said Grimshaw. However, he said, there is a substantial evidence base in behavioural sciences that can support the development of patient safety programs and increase the likelihood of success. He said this approach can add to the approaches already used in the patient safety field. Grimshaw said, while data and tools are enablers to support patient safety initiatives, they are not sufficient to have clinicians make changes. Grimshaw discussed the need for a behavioural perspective to change the actions of those who can make a difference. He also discussed how the science of modern psychology can be adapted to assist in patient safety initiatives. Grimshaw referenced a 4-step framework for successfully designing changes processes:

1. Identifying who needs to do what differently
2. Identifying the barriers and enablers to making this change
3. Identifying what interventions could overcome the barriers and enhance the enablers
4. Measuring behaviour change

Grimshaw then discussed a case study concerning an intervention to modify handwashing behaviour by physicians at Ottawa Hospital. He summarized his presentation by noting that patient safety remains a major concern in healthcare systems and that insights from behaviour science can help optimize change programs and increase their likelihood of success.

Grimshaw then engaged in a lengthy question and answer period with Leads participants touching on topics such as the value of involving patients directly to change clinician behaviour (Grimshaw's answer – patients can be very useful advocates and they should be empowered but patients should not be forced to be involved), and how to select behavioural interventions that will have a long-term impact.

Bringing it all Together

In the final session of the day, Leads Groups participants were asked to discuss and answer 3 questions:

1. What stands out to you from the evaluation results?
2. Do you see a link between what we have done in the past, what we are currently doing, and the plan for moving forward?
3. What evidence-based practices will lead us to our collective vision: that Canada has the safest health care in the world?

Some common themes emerged from the answers that were repeated through sessions on both days. These included:

- Focusing on ideas with the best chance of being successfully implemented and having an impact
- The need to continue to fully engage patients, families and caregivers and involve them in implementation processes
- The importance of educating patients and the public on patient safety issues
- Sustaining impact was identified as challenge
- Supporting linkages between Leads Groups to maximize knowledge spread and impact
- The importance of evaluation
- Adding behavioural science to implementation practices
- The need for a data repository

National Patient Safety Consortium—Oct. 12

CPSI CEO Chris Power welcomed delegates to the 5th face-to-face meeting of the National Patient Safety. She noted that many of the 104 individuals in attendance had been present at the previous day's Leads Groups meeting, which was a celebration of the collective progress made on the Integrated Patient Safety Action Plan (see Appendix C for the participant list). The day's meeting, she said, would involve a deeper look at National Patient Safety Consortium activities, learnings from experts, and a look towards the future.

Power went on to describe the operating structure of the National Patient Safety Consortium as well as its guiding principles which are as follows:

- Patients and families as partners
- Unprecedented collaboration
- Mobilization on common goals and actions
- Transparency of actions and results
- Accountability to patients, families, partner organizations, and stakeholders
- Commitment to improved quality of care
- Targeted and strategic communications
- Ongoing evaluation of the Integrated Patient Safety Action Plan

"Not only have we aimed to make healthcare safer for Canadians, we have changed the way the health system thinks about patient safety and the way it approaches patient safety problems," said Power. She then introduced meeting facilitator Maura Davies.

Davies outlined the meeting objectives as follows:

1. Engage in meaningful discussion and learning with National Patient Safety Consortium participants and experts on what is possible for national, transformative change in patient safety;
2. Demonstrate value of involving patients and families as full partners;
3. Review preliminary findings of the National Patient Safety Consortium and Integrated Patient Safety Action Plan evaluation; and
4. Celebrate progress and outcomes from the Integrated Patient Safety Action Plan.

Davies said a pre-meeting survey indicated most in the room were in support of these objectives. In addition, she said, respondents had requested to learn more about how patients and family members have been involved and to hear about what had changed or advanced since the last meeting of the National Patient Safety Consortium. She said these requests had been integrated into the program.

Partnering with Patients and Families for Patient Safety

Terri Sabo and Deborah Prowse gave a presentation as representatives as Patients for Patient Safety Canada. Sabo is one of the new co-chairs of PFPSC and someone who has directly experienced healthcare harm. "Not in my wildest dreams did I believe I would be involved with such a dynamic and passionate group of advocates. I'm overwhelmed." Sabo walked through how patients and families have been involved as partners in the National Patient Safety Consortium and the Integrated Patient Safety Action Plan. Through the process, she said 27 patients and families have been involved in developing and implementing the plan, with 12 patients and families currently involved. Prowse, a member of PFPSC, started by publicly acknowledging CPSI for involving patients so significantly in its work. She also discussed the report called The Case for Investing in Patient Safety in Canada which estimated that over the next 30 years, 12.1 million Canadians will be harmed by the health care system and 1.2 million will die. The estimated cost of this to the system will be 82 billion dollars. "We can do better," Prowse said, citing 3 recent examples of patients who have suffered avoidable harm. "We really need to make sure we are keeping patient safety as a priority.

> **"The single most common comment that I have heard in the 13 years of my involvement in patient safety advocacy is how having patients at the table really does change the conversation."**
>
> – Prowse

Asked what was at the top of their wish list to contribute to a breakthrough to move further faster for patient safety, Sabo said she wanted to see patients brought in as equal partners "not just to hear our stories" but also to benefit from the business skills these patients can bring. Personally, she said she also wanted to ensure that all the patients in the country who aren't advocates or involved in health care become aware of unsafe healthcare and involve themselves to keep themselves safe. Prowse talked about advocating "from bedside to boardroom" and the need to do more to ensure all health boards have representation by patient and family members who have had time to reflect on their experiences and bring this knowledge to the table. "We have great intentions, we have great principles, we have made a difference in patient safety but sometimes it is lost at the granular level," Prowse said, and there is a need to involve front-line providers so they can keep patient safety top-of-mind.

Davies said one of the most successful outcomes from the work of the National Patient Safety Consortium was the degree of patient involvement as outlined in the presentation by Sabo and Prowse and subsequent comments.

Celebrating Progress Video

A video shown outlining the success of the work of the National Patient Safety Consortium and the Integrated Patient Safety Action Plan to date, which had largely been prepared based on interviews over the previous 24 hours. These quotes represent just a few of the comments from that video:

"Collaboration is hugely important."– Chris Power, CEO, CPSI

"I really like the idea of action. That's what Canadians are looking for—patient-centred action."

"How can you not be excited to contribute to patient-safety? At the end of the day we are all patients we all have loved ones who need to experience good health and good experiences in the health care setting."

"We couldn't do this work without patients, we absolutely couldn't because we as care providers and leaders think we have the answers … but when we really deeply listen to what our patients and families have to tell us along the way we learn so much."

"Everybody can rally about keeping patients safe but how do we get there and how do we get sustained movement towards that? The landscape is always changing … but the constant is always the patient."

"I think this is actually going to truly transform how we deliver healthcare in Canada. … I'm sensing that we are tired about just talking about it (patient safety) and we want to get bold and we want to do things."

"My despair from losing our son has turned to hope and has turned to trust that we are going to see this to the end so every patient is safe."

Rapid Fire Presentations—Leads Groups and National Patient Safety Consortium

Representatives from the five Leads Groups gave abridged reports on the work of their groups to date that had been presented at the Leads meeting. Kathleen Morris, reported back on behalf of the National Patient Safety Consortium Steering Committee on outcomes of the work of the National Patient Safety Consortium itself. In addition to outlining achievements, presenters also discussed challenges that had been, or continue to be, faced and thoughts on the future. Overall, Morris noted 70% of the work by the Leads Groups and combined initiatives of the National Patient Safety Consortium had been completed by June 2017.

During question periods following these presentations, the Never Events initiative prompted the most lively and detailed discussion. This was prompted by Dr. Kaveh Shojania, Vice Chair (Quality and Innovation) for the Department of Medicine at the University of Toronto, who questioned the value of focusing and attempting to eliminate Never Events in hospitals. He said it was "somewhat Pollyannish" to believe that fixing problems resulting in these events could be solved easily because they happen for complex organizational reasons. Morris responded that looking at Never Events could prompt conversations and discussion that would improve patient safety and that initiative is part of a much broader plan. One patient advisor stated he was fully supportive of focusing on Never Events. "There is no reason why somebody needs to be operated on the wrong limb (an example of Never Event)". Another responded that while it might be impossible to eliminate Never Events they were a worthwhile target for improving safety.

National Patient Safety Consortium Preliminary Evaluation Results

As they had done on the previous day, Dr. San Ng, and Jean Trimnell provided preliminary findings from an extensive evaluation of the National Patient Safety Consortium and the Integrated

Patient Safety Action Plan. In this presentation, they went further and presented preliminary their recommendations to the National Patient Safety Consortium. The following were presented as preliminary recommendations:

1. Continue to use the National Patient Safety Consortium as a collective impact mechanism for improving patient safety, however, evolve the structure of the National Patient Safety Consortium and the roles of National Patient Safety Consortium partners and participants
    a. Determine the specific leadership roles and expectations for National, Provincial/Territorial, Regional and Local partners:
        i. Policy
        ii. Planning
        iii. Implementation
        iv. Evaluation/measurement
2. Continue to celebrate successful completion of actions and progress to date
3. Revisit the strategy and approach for evaluating and reporting progress and achievements to demonstrate impact
4. Identify and work with provincial/territorial and regional/local implementation partners to develop implementation strategies to promote the usage of key products/resources by front line providers and the public
5. Continue to work with provincial/territorial Deputy Ministers to develop strategies to deepen the commitment to a national agenda for patient safety improvement
    a. Set national priorities and strategies to achieve impact
    b. Leverage key enablers: leadership, funding, implementation, reporting and measurement
6. Celebrate the difference that has been made in:
    a. Building a national common vision
    b. Generating momentum through completion of concrete actions
    c. Developing a shared commitment
7. Develop strategies to realize the impacts of work completed to date and to sustain the momentum of the National Patient Safety Consortium
    a. Support the implementation of the products of the work
    b. Align and focus future national efforts
    c. Solidify partner commitment
8. Establish a shared set of indicators and a national measurement system to monitor and evaluate progress in patient safety
        i. Continue to develop priority area indicators
        ii. Complete benchmarking
        iii. Facilitate knowledge transfer and exchange
        iv. Evidence for policy, strategy, and investments

Brian Wheelock, chair of the CPSI Board of Directors said the evaluation report made it clear there was much to celebrate at the meeting and that the Board was very proud of the work that had been done. He said how the National Patient Safety Consortium might continue to function and who would lead and fund the initiative still needs to be addressed.

During discussion of the evaluation report there were many references to the need to better engage and involve provincial and territorial governments in patient safety initiatives and to align the National Patient Safety Consortium work with government priorities. Those government representatives present at the meeting who chose to comment voiced general support for the work of the National Patient Safety Consortium and the recommendations from the evaluation.

Ng said the report was not suggesting initiatives or approaches should be standardized across the country but rather there should be some sort of a national lens involved in setting priorities.

International Expert Panel

Wheelock introduced the two members of the panel, Dr. Tejal Gandhi, Chief Clinical and Safety Officer, at the Institute for Healthcare Improvement (IHI) and Associate Professor of Medicine at Harvard Medical School, and Dr. Kaveh Shojania, Vice Chair (Quality and Innovation) for the Department of Medicine and Director of the Centre for Quality Improvement and Patient Safety (C-QuIPS) at the University of Toronto.

Dr. Gandhi began by praising the National Patient Safety Consortium for its excellent work and noting that the U.S. could learn from some of the initiatives undertaken in the Integrated Patient Safety Action Plan. Dr. Gandhi's presentation focused on the Free from Harm report which reviewed work undertaken on patient safety since the ground breaking To Err is Human report was published in 1999. The report represented findings from an expert panel convened by the U.S. National Patient Safety Foundation that was intended to help accelerate progress in patient safety. She said the panel concluded that while there was mixed evidence to document improvements in patient safety since 1999 the panel had a uniform sense safety had improved. She said the panel felt the need to move from a "Whack a Mole" approach to addressing patient safety issues in a piecemeal fashion, to taking a total systems approach.

The report presented eight recommendations which Gandhi discussed in detail:

- Ensure that leaders establish and sustain a safety culture
- Create centralized and coordinated oversight of patient safety
- Create a common set of safety metrics that reflect meaningful outcomes
- Increase research in public safety and implementation science
- Address safety across the entire care continuum
- Support the healthcare workforce
- Partner with patients and families for the safest care
- Ensure that technology is safe and optimized to improve patient safety

"A lot has improved in patient safety and I want to say that very clearly," said Dr. Gandhi in her concluding remarks. "We need to make sure patient safety remains at the core of what we are doing."

In his provocative presentation, Dr. Shojania began by stating he was "here as a friend to give you critical feedback on how patient safety could improve," and his presentation was titled *Moving Patient Safety Forward by Learning How to do Quality Improvement*. Dr. Shojania was critical of current approaches to patient safety which often just did the following: Talk about importance of patient safety; name safety champions and launch campaigns; engage a few patients; call for more incident reporting; recommend interventions of unclear benefit and/or complex to implement; and wait for safety to magically improve. "Patient safety is something we talk about all the time but rarely actually do anything about," he said. He said patient safety should not be relegated to the backseat, but wanted to stress a focus on giving people the skills to initiate quality improvement projects. The two main conclusions from Dr. Shojania's presentation were:

- Achieving concrete goals in safety requires the same skills for developing and executing quality improvement projects
- We often have unrealistic ideas about the work required to have grand strategies and campaigns achieve any concrete impact

A lively discussion then covered a wide range of topics including different opinions on the value of incident reports documenting patient safety incidents and the value of a systems-based or national approach versus local initiatives. In summarizing these discussions, Davies said they highlighted the importance of leadership capacity and capacity at the point of care to deal with safety issues, the importance of properly resourcing safety initiatives, the importance of local context and the fact the science around successful implementation shows it is not as easy as it seems.

Looking Toward the Future

Prior to giving another overview of the CPSI strategic plan, Power began her presentation with reflections on the future of National Patient Safety Consortium. "How do we make sure all this great work does not die on the vine," she asked? She said when people were asked to sign on to the National Patient Safety Consortium in 2014 it was with the explicit recognition the work would conclude in March 2018 and that CPSI would operate under a new strategic plan in April 2018. She said many in the evaluation said the work could not just stop because there was so much to do and that the National Patient Safety Consortium should continue in some way. Power said no decisions will be made until the evaluation is finalized "but we wanted to be very open and honest with you that the funding for the National Patient Safety Consortium and amount of time and money CPSI has put into it is not reflected in new

strategy going forward as it was in the old strategy that will wind up in March 2018." She also noted any decision on the future of the National Patient Safety Consortium was not that of CPSI alone but for all participants to make. Power then discussed development of the new strategic plan as she had done with the Leads groups the previous day. In this presentation, Power explicitly mentioned the need for policy work in patient safety and engagement of federal, provincial and territorial governments. "Just think how powerful it would be if every province and territory, every one of us said here are the two things every single one of us are going to work on."

Two questions were then posed to the audience for discussion:

- How can we galvanize our efforts as a country to make this vision (of Canada being the safest healthcare in the world) a reality?
- What is your role or your organization's role in ensuring Canada has the safest healthcare in the world?

Answers to the first question ranged across a continuum from the need to raise awareness about the importance of patient safety to suggested strategies for integrating patient safety better into provincial/territorial health care systems.

On the issue of awareness comments from the small group discussions included:

- Public needs to know there is a national body funded by Health Canada, *because there is a need* (emphasis by authors)
- A lot of people don't know about patient safety problems.
- Focus on public awareness/support to galvanize focus on patient safety
- Galvanizing the country must be beyond this room

On the issue of better integrating patient safety efforts the following were a few of the comments made:

- Pick a few areas and have clear aims and targets
- Pick a safety problem that may resonate (and) piggyback on other work
- Call for innovations in safer practices in specific high leverage areas
- Set targets that every province and facility can align with
- Engage with pockets of excellence to learn what has worked
- Be broad and inclusive of different contexts
- Make patient safety a non-negotiable accountability set by governments/regulators
- We need an overarching body. Partners are powerful but not enough.

In answering the question of the role of specific organizations in ensuring Canada has the safest health care, groups provided some specific areas of focus based on the nature of their own organizations.

For example, representatives from HIROC (Healthcare Insurance Reciprocal of Canada) said they could use their position of strength and credibility on issues of risk and legal exposure to drive patient safety. One group wrote that provincial ministries of health through a pan-Canadian collaboration could share learnings and inform a national agenda. Educational groups representing nurses, physicians and pharmacists said they groups could provide more education and certification in patient safety to influence the next generation. "Our organization can promote primary care as part of the solution and not just the problem," was the comment made by another table. "Contribute to what we align with," another group wrote. "No-one is doing implementation, we're all developing standards," was another comment.

Other comments made in response to the two questions included:

- Find ways to prevent errors rather than telling healthcare professionals not to make a mistake
- Consider whether our efforts are removing joy in work
- What turns passion into performance? What are the motivators?
- Celebrate more successes and best practices

In her summary, Davies also noted some comments suggesting the National Patient Safety Consortium would benefit from focusing on the World Health Organization initiative on medication safety where Canada and CPSI has committed to taking a lead role. She also noted how patient voices had been heard "loud and clear" throughout the day.

Summary

Donna Davis, the past-co-chair of Patients for Patient Safety Canada provided a heartfelt summary of the meeting from the patient perspective. "If CPSI is the guardian of patient safety, we across the land are the wards of patient safety because at some time in our lives we or our loved ones we will be impacted by patient safety." Davis said throughout the day there had been acknowledgement of the need and value of having patients and families at the table. However, she added, this did not mean the burden of ensuring patient safety should be offloaded onto patients. "It's not the patients responsibility to receive good care," she said. Davis noted collaboration between stakeholders was

repeatedly mentioned as the key to the success of the National Patient Safety Consortium. She said there needed to be more frontline staff involved to bring initiatives to the bedside. “We see there needs to be fewer actions with more focus,” and utilizing the spread of good ideas by better involving Accreditation Canada because of their involvement with so many hospitals. “Much has improved but we have a long way to go,” she said. Davis concluded by talking about the strength and commitment of PFPSC members.

Power then brought the meeting to a close by touching again on the key themes of the day. “The rates of harm are still staggering, they absolutely are and that’s our wake-up call.” And she asked everyone to be purposeful in how they approached patient safety with the wisdom, passion and courage that they had for the issue.

> **“We were the one in 18 harmed. Our loved one was the one in eight that died.”**
>
> – Davis commenting on Patients for Patient Safety Canada

Next Steps

- The next Quarterly Newsletter will showcase this collaboration as we continue to celebrate their success
- The evaluation findings of the Consortium and Integrated Patient Safety Action Plan will be available in 2018.
- From the meeting evaluations, many attendees asked, “what is next for the National Patient Safety Consortium?”

We welcome your feedback into the path forward. Please contact us at nationalconsortium@cpsi-icsp.ca
if you would like to be part of Focus Groups that discuss the potential role of the Consortium going forward.

Appendix A- Meeting Evaluations

Leads Day Meeting Evaluation

54 people attended Leads Day on October 11, 2017, the day before the National Patient Safety Consortium, in Toronto, Ontario. A meeting evaluation was provided to participants at the end of the day. Twenty-seven (54%) of participants completed the evaluation for Leads Day. Of those 27 completed evaluations, 1 was done by CPSI staff. The key evaluation finds are summarized below.

Meeting Objectives

The first set of questions asked participants to use a 5-point scale of strongly disagree to strongly agree (1-5) indicating the extent to which they agreed or disagreed with the following statements about the meeting objectives, materials and facilitation.

	Strongly Agree or Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	# of Responses
Leads group members will feel reenergized about their contributions to advancing patient safety across Canada through the Integrated Patient Safety Action Plan.	24 (92%)	2 (7%)	1 (3%)	27
Leads group members will receive a progress update from each area of focus.	24 (92%)	2 (8%)	0	26
Leads group members will discuss advancing specific actions from the Integrated Patient Safety Action Plan.	21 (81%)	5 (19%)	0	26
Leads group members will build new and strengthen existing relationships with individuals from various Leads Groups.	19 (76%)	5 (20%)	1 (4%)	25
Overall, the objectives of today were achieved.	**20 (90.0%)**	**2 (10%)**	**0**	**22**
The pre-meeting materials were clear and helped me to prepare for the meeting.	21 (81%)	5 (19%)	0	26
Facilitation				
The facilitator was well organized.	27 (100%)	0	0	27
The facilitator made good use of the time allocated.	26 (100%)	0	0	26
Sufficient time was allowed for audience participation and discussion.	25 (96%)	1 (4%)	0	26

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Venue (5 = Excellent, 1 = Poor)	Excellent (4-5)	3	Poor (1-2)	
Omni	21 (78%)	6 (22%)	0	27
Catering	24 (96%)	1 (4%)	0	25
Audio	23 (89%)	1 (11%)	0	27
Visual	25(93%)	2 (7%)	0	27

1. What was the most meaningful/valuable part of the day, from your perspective?

- Presentation on implementation science
- Meeting with my Leads Group face to face
- Listening to and learning from the other Leads Groups
- Seeing the new CPSI strategic plan Identifying opportunities to link successful initiatives for more success
- Agreement on need to focus and strategic resourcing by all groups

2. What was the least meaningful/valuable part of the day, from your perspective?

- Some presentations were not compelling/dynamic nor explicitly connected to the work of the Leads Groups
- Silo thinking (providers vs patients)
- Slides on progress to date from areas of focus – some "over details"
- At times, it felt that discussion could not go deep enough and excellent ideas were not captured

3. Were there any topics / issue areas that we did not discuss which you believe are critical to advancing the work in each of the Leads groups' areas of focus?

- What's happening beyond March 31, 2018, in terms of resources, people, funding
- Liaison with provincial health systems and the role of governments
- Policy and system changes that need to support these changes
- How to disseminate and spread
- Take careful stock of feedback and implications and prioritize in terms of work ahead

4. What is the next most critical step to ensure that the work of today's meeting further advances patient safety?

- Identify the transition strategy for 2018 and beyond; which will be priorities for CPSI moving forward?
  Based on evidence and priorities.
- Prioritize and focus resources, on implementation, action and spread
- Involve patients and frontline providers in implementation plans
- Alignment among groups re-focusing on collective aim. Build line of sight between people, organizations, Leads Groups, and National Patient Safety Consortium.

National Patient Safety Consortium Meeting Evaluation

The National Patient Safety Consortium met for the fifth time on October 12, 2017. A meeting evaluation was provided to participants at the end of the day. Thirty-nine per cent (n= 41) of 104 participants completed a meeting evaluation. The key findings are summarized below.

Meeting Objectives

- The first six questions asked on a five-point scale of strongly disagree to strongly agree whether the meeting objectives had been met:

Meeting Objectives	Strongly Agree or Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Responses
Engage in meaningful discussion and learning with National Patient Safety Consortium participants and experts on what is possible for national, transformative change in patient safety;	32 (80%)	5 (13%)	3 (8%)	40
Demonstrated value of involving patients and families as full partners;	40 (100%)	0	0	40
Review preliminary evaluation findings of the National Patient Safety Consortium and Integrated Patient Safety Action Plan; and	37 (90%)	3 (7%)	1 (2%)	41
Celebrate progress and outcomes from the Integrated Patient Safety Action Plan.	32 (82%)	7 (18%)	0	39
Overall, the objectives of today were achieved.	**30 (97%)**	**1 (3%)**	**0**	**31**

Meeting Materials and Facilitator

- 83% either strongly agreed or agreed that the "pre-meeting materials were clear and helped me prepare for the meeting." 11% neither agreed nor disagreed with the statement.
- 97% either strongly agreed or agreed that the facilitator was well organized. 3% neither agreed nor disagreed with the statement.
- 98% either strongly agreed or agreed that the "facilitator made good use of the time allocated". 2% neither agreed nor disagreed with the statement.
- 90% either strongly agreed or agreed that "sufficient time was allowed for audience participation and discussion". 5% neither agreed nor disagreed with the statement, and 5% disagreed with the statement.

Meeting Facilities

- All respondents ranked the following meeting facilitates as 4 out of 5, or 5 out of 5 (excellent): The Omni King Edward Hotel (100%), Catering (100%), Audio (100%), and Visuals (100%).

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Qualitative Questions

Four open ended questions were asked and the key findings are listed below:

1. Were there any topics / issue areas that we did not discuss which you believe are critical to advancing the work of the National Patient Safety National Patient Safety Consortium?
   - More detailed discussion on next steps and where to from here
   - Primary care
   - How to celebrate and share best practices nationally
2. What was the most meaningful/valuable part of the day from your perspective?
   - Patient and family member involvement
   - International Expert Panel, “provocative discussion”, “healthy debate”, “challenges current thinking”
   - Rapid Fire presentations
   - Networking, discussion, questions periods
   - “To be honest the agenda was well crafted. Middle panel with experts was disruptive in a good way. Last session on CPSI well done.”
3. What was the least meaningful/valuable part of the day from your perspective?
   - Evaluation session could have been briefer and supplemented with a report on findings
   - More interaction throughout the day, not enough time at breaks to network
   - Some repetition from previous day
4. What is the next most critical step to ensure that the work of today’s meeting further advances the Integrated Patient Safety Action Plan?
   - Include front line staff and messages/evidence out to the public
   - What is next for the National Patient Safety Consortium? A clear plan going forward.
   - Patient engagement and awareness of patient safety challenges in Canada
   - Implementation
   - “Communication with National Patient Safety Consortium members to keep everyone apprised of next steps”
   - “Refine and focus our aspirations into real plans for QI at the frontline/bedside level”
   - “I would hope the National Patient Safety Consortium can continue, perhaps with a new focus but maintaining connections and momentum that has been built”
   - “Keen to engage on a focused goal in patient safety”

Appendix B- Leads Day Participant List

First Name	Last Name	Organization
Markirit	Armutlu	Canadian Patient Safety Institute
Maaike	Asselbergs	Patients for Patient Safety Canada
Cecilia	Bloxom	Canadian Patient Safety Institute
Jan	Byrd	Canadian Patient Safety Institute
Mike	Cass	Canadian Patient Safety Institute
Maryanne	D'Arpino	Canadian Patient Safety Institute
Maura	Davies	Canadian Patient Safety Institute
Donna	Davis	Patients for Patient Safety Canada
Joan	Fernandez	Canadian Patient Safety Institute
Ward	Flemons	University of Calgary
Virginia	Flintoft	Canadian Patient Safety Institute
Riccarda	Galioto	AMMI Canada
Corina	Ganton	Canadian Patient Safety Institute
Jeremy	Grimshaw	Ottawa Hospital Research Institute
Gerry	Hansen	IPAC Canada
Linda	Hughes	Patients for Patient Safety Canada
Sylvia	Hyland	ISMP Canada
Sandi	Kossey	Canadian Patient Safety Institute
Arlene	Kraft	Healthcare Insurance Reciprocal of Canada
Helene	Lacroix	Saint Elizabeth
Hina	Laeeque	Canadian Patient Safety Institute
Claude	Laflamme	Canadian Anesthesiologists' Society
Eric	Lamoureux	Canadian Patient Safety Institute
Lorraine	LeGrand Westfall	Canadian Medical Protective Association
Anne	MacLaurin	Canadian Patient Safety Institute
Dee	Mangin	McMaster University
Bonnie	McLeod	Operating Room Nurses' Association of Canada
Wayne	Miller	Canadian Patient Safety Institute

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First Name	Last Name	Organization
Richard	Mimeault	Canadian Medical Protective Association
Kim	Neudorf	Patients for Patient Safety Canada
San	Ng	Vision and Results Inc.
Brian	Penner	Patients for Patient Safety Canada
Donna	Penner	Patients for Patient Safety Canada
Ioana	Popescu	Canadian Patient Safety Institute
Chris	Power	Canadian Patient Safety Institute
Caroline	Quach	AMMI Canada
Suzanne	Rhodenizer Rose	IPAC Canada
Jill	Robbins	Canadian Home Care Association
Spencer	Ross	Canadian Institute for Health Information
Steve	Routledge	Canadian Patient Safety Institute
Terri	Sabo	Patients for Patient Safety Canada
Susan	Sepa	Canada Health Infoway
Tricia	Swartz	Canadian Patient Safety Institute
Alex	Titeu	Canadian Patient Safety Institute
Johanna	Trimble	Patients for Patient Safety Canada
Jean	Trimnell	Vision and Results Inc.
Ellen	Tsai	Canadian Medical Protective Association
Timothy	Willett	SIM-one
Carla	Williams	Canadian Patient Safety Institute

Appendix C- National Patient Safety Consortium Participant List

First Name	Last Name	Organization
Brendan	Abbott	Ministry, British Columbia Department of Health
Claude	Allard	Ministry, New Brunswick Health
Maaike	Asselbergs	Patients for Patient Safety Canada
Angela	Bachynski	Ministry, Manitoba Department of Health, Healthy Living and Seniors
Cynthia	Baker	Canadian Association of Schools of Nursing
Francois	Belanger	Alberta Health Services
Cecilia	Bloxom	Canadian Patient Safety Institute
Elaine	Borg	Canadian Nurses Protective Society
Alex	Boudreau	Ministry, Alberta Health
Gavin	Brown	Health Canada
Jan	Byrd	Canadian Patient Safety Institute
Elizabeth	Carlton	Ontario Hospital Association
Mike	Cass	Canadian Patient Safety Institute
Paul Emile	Cloutier	HealthCare*CAN*
Janet	Cooper	Association of Faculties of Pharmacy of Canada
Kim	Critchley	Ministry, Prince Edward Island Department of Health and Wellness
Danton	Danielson	Canadian Patient Safety Institute
Maryanne	D'Arpino	Canadian Patient Safety Institute
Maura	Davies	Facilitator
Donna	Davis	Patients for Patient Safety Canada
Denise	Durfy Sheppard	Ministry, Newfoundland and Labrador Department of Health and Community Services
Brendalynn	Ens	Canadian Agency for Drugs and Technologies in Health
Lee	Fairclough	Health Quality Ontario
Joan	Fernandez	Canadian Patient Safety Institute
Ward	Flemons	University of Calgary
Virginia	Flintoft	Canadian Patient Safety Institute
Riccarda	Galioto	AMMI Canada

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First Name	Last Name	Organization
Corina	Ganton	Canadian Patient Safety Institute
Catherine	Gaulton	Healthcare Insurance Reciprocal of Canada
Tejal	Gandhi	Institute for Healthcare Improvement
Asmita	Gillani	Accreditation Canada
Jeremy	Grimshaw	Ottawa Hospital Research Institute
Ron	Guse	Canadian Patient Safety Institute Board Member
Gerry	Hansen	IPAC Canada
Janet	Hodder	Atlantic Health Quality and Patient Safety Collaborative
Linda	Hughes	Patients for Patient Safety Canada
Sylvia	Hyland	ISMP Canada
Ruby	Knowles	Ministry, Nova Scotia Department of Health and Wellness
Sandi	Kossey	Canadian Patient Safety Institute
Arlene	Kraft	Healthcare Insurance Reciprocal of Canada
Helene	Lacroix	Saint Elizabeth
Hina	Laeeque	Canadian Patient Safety Institute
Claude	Laflamme	Canadian Anesthesiologists' Society
Eric	Lamoureux	Canadian Patient Safety Institute
Angele	Landriault	Royal College of Physicians and Surgeons of Canada
Lorraine	Legrand Westfall	Canadian Medical Protective Association
Anne	MacLaurin	Canadian Patient Safety Institute
Shelagh	Maloney	Canada Health Infoway
Michelina	Mancuso	New Brunswick Health Council
Dee	Mangin	McMaster University
John	Maxted	The College of Family Physicians of Canada
Bonnie	McLeod	Operating Room Nurses' Association of Canada
Wayne	Miller	Canadian Patient Safety Institute
Richard	Mimeault	Canadian Medical Protective Association

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First Name	Last Name	Organization
Debbie	Molloy	Newfoundland Labrador Quality, Patient Safety Provincial Committee
Kathleen	Morris	Canadian Institute for Health Information
Kim	Neudorf	Patients for Patient Safety Canada
Andrew	Neuner	Health Quality Council of Alberta
San	Ng	Vision & Results Inc.
Christine	Nielsen	Canadian Society of Medical Laboratory Sciences
Maureen	O'Neil	Canadian Foundation for Healthcare Improvement
Jillian	Paul	Ministry, Ontario Ministry of Health and Long-Term Care
Brian	Penner	Patients for Patient Safety Canada
Donna	Penner	Patients for Patient Safety Canada
Kathy	Perrin	Ministry, Nunavut Department of Health
Valerie	Phillips	Ministry, Saskatchewan Health
Ioana	Popescu	Canadian Patient Safety Institute
Chris	Power	Canadian Patient Safety Institute
Deborah	Prowse	Patients for Patient Safety Canada
Caroline	Quach	AMMI Canada
Suzanne	Rhodenizer Rose	IPAC Canada
Pat	Rich	Report Writer
Ben	Ridout	British Columbia Patient Safety and Quality Council
Jill	Robbins	Canadian Home Care Association
Nancy	Roberts	Ministry, New Brunswick Health
Spencer	Ross	Canadian Institute for Health Information
Stephen	Routledge	Canadian Patient Safety Institute
Myrella	Roy	Canadian Society of Hospital Pharmacists
Terri	Sabo	Patients for Patient Safety Canada
Susan	Sepa	Canada Health Infoway
Karen	Sequeira	Ontario Hospital Association
Kaveh	Shojania	University of Toronto
Karey	Shuhendler	Canadian Nurses Association
Rani	Srivastava	Academy of Canadian Executive Nurses

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First Name	Last Name	Organization
Polly	Stevens	Healthcare Insurance Reciprocal of Canada
Lisa	Stromquist	Canadian Association of Paediatric Health Centres
Neil	Stuart	Patients Canada
Patricia	Sullivan Taylor	Health Standards Organization
Tricia	Swartz	Canadian Patient Safety Institute
Leslee	Thompson	Health Standards Organization
Laurie	Thompson	Manitoba Institute for Patient Safety
Alex	Titeu	Canadian Patient Safety Institute
Johanna	Trimble	Patients for Patient Safety Canada
Jean	Trimnell	Vision & Results Inc.
Ellen	Tsai	Canadian Medical Protective Association
David	U	ISMP Canada
Brian	Wheelock	Canadian Patient Safety Institute Board Member
Timothy	Willett	SIM-one
Carla	Williams	Canadian Patient Safety Institute