NATIONAL PATIENT SAFETY CONSORTIUM

3rd Meeting Report, September 18, 2015
Prepared on December 1, 2015

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Executive Summary

> "What you (Consortium) are doing is brilliant. Keep doing what you are doing and go as far and as fast as you can."
>
> - Dr. David Naylor

- On September 18, 2015 in Toronto, the National Patient Safety Consortium met face-to-face for the third time. This report is a summary of the meeting proceedings. The third meeting involved 45 participating organizations, including seven new organizations.
- Consortium participants received an update on the Integrated Patient Safety Action Plan, presentations on the progress of each area of focus (surgical care safety, medication safety, infection prevention and control, home care safety, and patient safety education), and an overview of the evaluation plan for this work.
- Small group discussions focused on:
    - Never Events – Next Steps
    - Identifying Gaps in Patient Safety
    - Recommending Patient Experience Measures
    - Building a National Patient Safety Scorecard
- Live poll results demonstrate high degree of engagement and good degree of trust and cooperation among the Consortium participants.
- 25 individuals completed a meeting evaluation (56%). Meeting evaluations are strong, with 92% (n=23) stating that the meeting objectives were met overall.

The time for MOMENTUM is NOW.

- You can build momentum by:
    1. Tell the story of the great work you are involved in by using the communication products within your organization, on your website, and through your existing networks:
        a. Infographic Video: Patient Safety is our collective responsibility
        b. Integrated Patient Safety Action Plan video
        c. Strategic Communications Plan (provided in meeting materials)
        d. Stakeholder Toolkit (provided in meeting materials)
    2. Lead/Co-Lead/Partner organizations continue to advance the Integrated Patient Safety Action Plan.
    3. Provide any feedback to nationalconsortium@cpsi-icsp.ca.
- The next steps for the Canadian Patient Safety Institute as the coordinating body are to:
    1. Continue to work with participants and coordinate the Integrated Patient Safety Action Plan
    2. Provide clear and deliberate messaging on how to communicate the work
    3. Convene the Evaluation Action Team

BACKGROUND

On January 27, 2014, healthcare leaders from across Canada met in Toronto to shift patient safety into higher gear to help transform our current system. They gathered at the invitation of the Canadian Patient Safety Institute (CPSI), which made a commitment to work with partners to accelerate patient safety, including four initial areas of focus: surgical care safety, medication safety, home care safety, and infection prevention and control. It was essential, in CPSI's view, to start with creating a consortium, because any effort to drive real change in safety would have to be much bigger than one organization could manage, and could not succeed if it were seen to be solely one organization's agenda. Emerging from the January 2014 meeting was the foundation of a National Patient Safety Consortium with a clear action plan to advance patient safety across the country.[1] The first Consortium meeting report called "Forward with Patient Safety: Commitment Through action" outlines key actions to advance patient safety.

Over the course of 2014, CPSI hosted, with several partners, a series of meetings to develop respective and specific action plans for surgical care safety, medication safety, home care safety, infection prevention and control, and patient safety education. CPSI then consolidated the Consortium and the individual action plans into an Integrated Patient Safety Action Plan.

The second National Patient Safety Consortium meeting was held on November 27, 2014 and a third on September 18, 2015 in Toronto. This report is a summary of the meeting proceedings of that third meeting. The third meeting was interactive with live polling as well as the creation of a live video involving participants in the room. This report describes the poll results, includes links to the videos, and describes the key outcomes of the meeting. It also highlights examples of participants acting on their commitment, the discussions, and next steps. A summary of the meeting evaluation can be found in Appendix A.

MEETING SUMMARY

The third meeting of the National Patient Safety Consortium was held in Toronto, Ontario and involved 45 participating organizations (see Appendix B for the list of organizations). This included seven new organizations to the work:

- Alberta Health Services
- Canadian Association of Paediatric Health Centres (CAPHC)
- Canadian Society of Medical Laboratory Sciences
- Infection and Prevention Control Canada
- New Brunswick Department of Health
- Saskatchewan Ministry of Health
- Ontario Hospital Association

The day opened with a key note presentation from Dr. David Naylor entitled "Unleashing Innovation: ~~Excellent~~ Safer Healthcare for Canada" and reviewed the findings of the Advisory Panel of Healthcare Innovation.

A patient video helped set the context for the work, with the story of Nicholas Bravi. Nicholas had been diagnosed with a heart condition called Wolff-Parkinson-White syndrome, an abnormality of the electrical system of the heart that can cause rapid and erratic heart rates. He'd been symptom free for several years but fell ill one day at his Penticton school with a racing heart. In the video Nicholas' mother, Carola, describes what they went through and her pursuit for full information on why it occurred.

CPSI provided an overview of the work completed to date such as the final Consortium purpose, outcome, and governance structure as agreed upon by Consortium participants since the last meeting (see Appendix C). An overview of the Integrated Patient Safety Action Plan was provided through this infographic video. The guiding principles for the Consortium were also updated to the following:

- Patients and families as partners

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

- 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
- On-going evaluation of the Integrated Patient Safety Action Plan

In order to help communicate this work, a Strategic Communications Plan and Stakeholder Toolkit were also presented and previously shared in the meeting materials. Lastly, Lead/Co-Lead organizations provided their progress updates (also found in meeting materials) and lessons learned for each area of focus for the 2014-2016 actions. Some key activities and actions from April to June 2015 were also highlighted:

Integrated Patient Safety Action Plan

- The Integrated Patient Safety Action Plan is built with an unprecedented level of collaboration and shared leadership from across Canada. Collectively we will drive a shared action plan for safer healthcare. This will create the synergy and coordination required to increase the pace of improvement in patient safety in Canada.
- The Integrated Patient Safety Action Plan is the key outcome document from seven meetings that combines and integrates all of the actions developed as the collaborative result of proceedings at the Consortium, Surgical Care Safety Summit, Medication Safety Summit, Home Care Safety Roundtable, Infection Prevention and Control Summit and the Patient Safety Education Roundtable.
- A voluntary structure supports the shared purpose: “to drive a shared action plan for safer healthcare for Canadians” (see Appendix C).
- On average, of the 2014-2016 actions 37% of actions are complete and 63% remain to be completed. This is a strong start for the first quarter of the year.

National Patient Safety Consortium

- In 2014, the Canadian Patient Safety Institute brought together key partners in Canadian healthcare and established the National Patient Safety Consortium to drive a shared action plan for safer healthcare. The governance structure is now established with includes a Steering Committee, Leads Groups, Action Teams, and CPSI as the coordinating body (see Appendix C).
- The Consortium Steering Committee (member list found in Appendix D) met in July and August 2015.
- 70% of the 2014-2016 actions have started, 18% of actions are complete, 6% of actions are scheduled to start later, and 6% of actions were expected to start but were delayed.
- Health Quality Ontario highlighted (on behalf of the group of organizations across the country that had contributed to the work) the Never Events for Hospital Care in Canada report, which was publicly launched that day and garnered significant media attention. Identifying never events for hospital care in Canada contributes to the Consortium goal of enabling the system to monitor progress in patient safety improvement. Key next steps are further distribution and perhaps a complementary list of “always events.”

Surgical Care Safety

- The Surgical Care Safety Leads group (member list found in Appendix D) met in August 2015.
- 56% of the 2014-2016 surgical care actions have started and 11% have been completed, 33% are scheduled to start later.
- The Health Insurance Reciprocal of Canada and

the Canadian Medical Protective Association are conducting a retrospective analysis of surgical harm from medical-legal data. Broadly sharing this retrospective analysis will further enhance learning from surgical patient safety incidents across Canada.

Medication Safety

- The Medication Safety Leads group (member list found in Appendix D) met in September 2015.
- 62% of the 2014-2016 actions are started and 38% are scheduled to start later.
- ISMP Canada and the Canadian Institute for Health Information are co-leading an environmental scan and white paper to identify all reporting systems that could provide medication incident data to a central access point for sharing and learning. This white paper is the first step in enhancing reporting, learning, and sharing of medication incidents.

Home Care Safety

- The Home Care Safety Leads group (member list found in Appendix D) met in September 2015.
- 60% of the 2014-2016 actions are scheduled to start later, 20% of actions have started, and 20% have been completed.
- A Home Care Faculty has been established and a Home Care Medication Safety Getting Started Kit is being launched, both of which advance the use of evidence-based leading practices in the home care sector to reduce risk and improve client safety.
- An environmental scan on client's right to live at risk and partnering with clients and families has been completed. This action is the first step toward the goal of identifying or developing resources to help guide the understanding and planning efforts of providers, clients, and family caregivers about risk in home care.

Infection Prevention and Control

- 67% of the 2014-2016 actions are started, and 33% of the actions are completed.
- IPAC Canada and the Association of Medical Microbiology and Infectious Disease Canada (AMMI Canada) are co-leading an action to create a pan-Canadian set of standardized case definitions for surveillance of healthcare-associated infections. A working group has convened and established a work plan. This action is the first step toward advancing the ultimate goal of pan-Canadian adoption of an agreed upon set of common indicators for healthcare-associated infections.

Patient Safety Education

- The Patient Safety Education Leads group (member list found in Appendix D) met in September 2015.
- There are 12 patient safety education actions in total, two of which are planned for the current fiscal year. These two actions will help to establish knowledge and skill development in patient safety and quality improvement as requirements for healthcare leadership, and work to ensure patient safety and quality improvement is part of education and training for all healthcare students/trainees and providers.

The key lessons learned across the areas include: the critical importance and value of positive relationships and partnerships, trust and openness to feedback, and having clear timelines and project scope.

> "This is a big job, it is going to take a collective team effort, and collective team efforts just don't happen. It will require all of us to be on the same page which is what the plan does and moving forward for the benefit of Canadians."

Key Outcomes of the Meeting – Live Poll Results

A series of live poll questions were asked of all participants in the room. The initial questions focused on knowledge and understanding of this work. By the end of the day, the questions focused on commitment and engagement. Participants were asked their familiarity with the work of the Consortium and their familiarity with the Integrated Patient Safety Action Plan. This was asked in the morning and repeated before the close of the day. Familiarity with both had grown notably by the end of the day, particularly for familiarity with the Integrated Patient Safety Action Plan.

Table 1. How familiar are you with the progress of the National Patient Safety Consortium?

Morning			Afternoon		
	Count	**Percent**		**Count**	**Percent**
Not familiar	2	6%	**Not familiar**	0	0
Somewhat familiar	10	28%	**Somewhat familiar**	4	16%
Familiar	13	36%	**Familiar**	10	40%
Very Familiar	11	31%	**Very Familiar**	11	44%
Total	36		**Total**	25	

Table 2. How familiar are you with the Integrated Patient Safety Action Plan?

Morning			Afternoon		
	Count	**Percent**		**Count**	**Percent**
Not familiar	3	8%	**Not familiar**	0	0
Somewhat familiar	15	38%	**Somewhat familiar**	6	22%
Familiar	17	44%	**Familiar**	12	44%
Very Familiar	4	10%	**Very Familiar**	9	33%
Total	39		**Total**	27	

A poll of the audience was taken to assess commitment to the Integrated Patient Safety Action Plan. Participants were asked, "Where is your organization currently with respect to commitment to the Integrated Patient Safety Action Plan?" The majority of participants were committed to "help it happen" or "make it happen". A few said "let it happen", and one stated they were new to this work. None in the room were opposed to the work (see Appendix E for the live poll visuals).

A presentation was provided on the Evaluation Plan of the Consortium and the Integrated Patient Safety Action Plan (which had been circulated to meeting participants in their meeting package) and a request made for meeting participants to join the Evaluation Action Team. Participants provided verbal feedback on the Evaluation Plan, which will be considered by the Evaluation Action Team. The Action Team will further refine and implement the evaluation plan. All participants were asked the following three questions through the live poll:

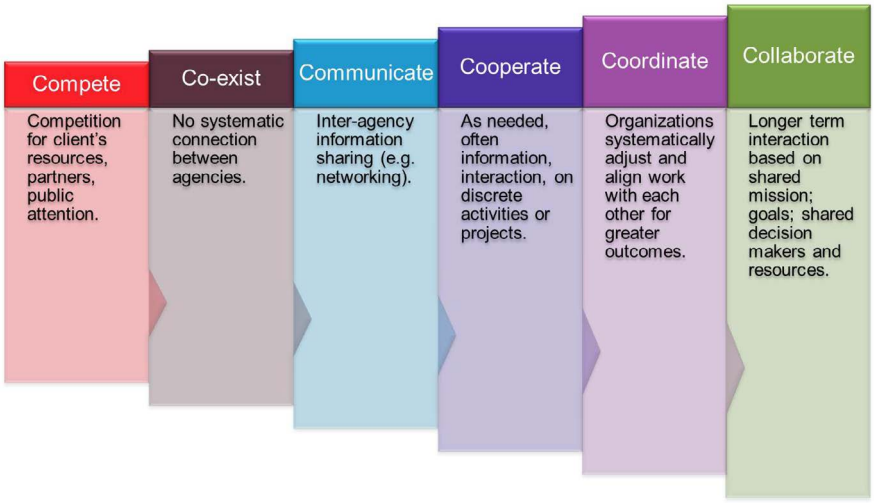
Table 3. Results for Live Poll Evaluation Questions

Questions	Yes (n)	No (n)	Not Sure (n)	Total Responses
1. Are you clear on your role in implementing the Integrated Patient Action Plan?	43% (17)	26% (10)	31% (12)	39
2. Do you understand how your role in the Integrated Patient Safety Action Plan contributes to improved patient safety?	48% (16)	6% (2)	45% (15)	33
3. Do you believe your role in the Integrated Patient Saftey Action Plan complements oters' roles in improving patient safety?	73% (29)	8% (3)	20% (8)	40

These results demonstrate that there is room for improvement both on role clarity for implementing the plan and how their role in the plan contributes to patient safety. However, 73% do feel this works complements the work of others in improving patient safety.

By the end of the day, to assess the degree of collaboration, the Collaboration Spectrum and definitions from the Collective Impact literature was shared with participants (see Figure 1). Participants were asked "where is your organization on the Collaboration Spectrum for the National Patient Safety Consortium?". One participant responded with "communicate", 11 responded with "cooperate", 7 responded with "coordinate", and 5 responded with "collaborate" for a total of 24 responses. No participants responded with "compete" or "co-exist" (see Appendix E for the live poll visuals). These results indicate a good degree of trust and cooperation among Consortium participants.

Figure 1. Collaboration Spectrum



Lastly, a Pyramid of Engagement (see Figure 2) and definitions was shared with participants who were then asked "which best describes the current state of your organization with respect to the Integrated Patient Safety Action Plan?". Nine participants stated "leadership", six stated "commitment", nine stated "participation", and three stated "interest" for a total of 27 responses. (see Appendix E for the live poll visuals). These results demonstrate the high degree of engagement among Consortium participants.

Figure 2. Pyramid of Engagement

"It's the degree of collaboration, it's the strength and commitment from organizations around the table, and its one action plan, I think that is the strongest asset."

Key Outcomes of the Meeting – Table Discussions

The afternoon centered on advancing the Consortium actions for 2016-2018. The discussions focused on four actions:

- Never Events – Next Steps
- Identifying Gaps in Patient Safety
- Recommending Patient Experience Measures
- Building a National Patient Safety Scorecard

Participants discussed whether these actions were still relevant (or needed to be modified), and identified any complementary work in the system. This information will help inform the Action Teams as they get started on these actions. Below is a summary of the discussions:

Never Events: Many felt this was a very relevant action since the final report called Never Events for Hospital Care in Canada had just been released. Several participants were questioning what their role and expectations would be in communicating the work more broadly within their organization and beyond. Some wanted tools for communication and clarity on how this would be communicated or the "choreography" across the country. Complementary work may include required organizational practices (ROPs) from Accreditation Canada and the Surgical Care Safety Action Plan.

Identifying Gaps in Patient Safety: This action is still relevant. Some felt that culture, primary care, vulnerable populations (seniors and mentally ill), and transitions of care are missing from the current work. However, with transitions of care there are various opinions regarding who owns the space, role ambiguity, and variations in roles and responsibilities. Leadership would be needed to address patient safety issues in transitions of care. An opportunity could be engaging the public to identify gaps and solutions.

Recommending Patient Experience Measures: A modification to this action was recommended to "identify and establish national standards for patient experience measures for patient safety." Five measures were thought to be too many. Instead, two to three indicators specific to long term care, home care, primary care, and mental health were preferred. These measures could be operationalized by Accreditation Canada or CIHI. For next steps, existing work and measures should be reviewed, , followed by testing, collecting, and reporting on data. The work of CIHI and Accreditation Canada could also be leveraged. Lastly, the forthcoming Action Team may want to differentiate between patient reported versus patient important measures.

Building a National Patient Safety Scorecard: As a start, participants suggested that we need to have a better understanding of current data that is available and collected and discover what may be missing. This should be a balanced scorecard with validated indicators. Currently, Canada collects a lot of data and many groups are undertaking similar tasks. Thus, it may be helpful to conduct a survey on what is currently being collected and by whom. Contributing to national benchmarking was also seen as possible.

Getting to Further Commitment and Action

After discussing specific actions, participants considered how to drive action and commitment to the Integrated Patient Safety Action Plan within their own organization, how to engage other audiences, and how reach those audiences individually and collectively. Below is a summary of the small group discussions.

Building on the commitment: Several representatives mentioned that their organizations have aligned their strategic plans with the Integrated Patient Safety Action Plan or helped to inform their organizational work, have staff dedicated to roles, are working on engaging others (e.g. awareness among the Western CEO Forum), and sharing reports and progress within their own organization. Consortium participants recommended having internal standing meetings on the Integrated Patient Safety Action Plan.

"The thing I want to make sure of is that just we keep going ahead and striving for speed because that is the kind of thing that coalitions sometimes succumb to is slowing down or watering down."

"Having patients and families at the forefront is absolutely fundamental to this work."

One association has a conference series aligned with the four areas of focus (surgical care safety, medication safety, home care safety, and infection prevention and control).

Engaging other audiences: Communication will be critical going forward, particularly when engaging other audiences. The need to engage with existing networks and utilize social media platforms was recommended several times (particularly to leverage the work on Never Events). However, engagement needs to be purposeful and coordinated in terms of what can be done centrally by the Consortium versus locally by individuals. How we engage governments also needs clarification. Some suggested to keep the messages simple, clear, and fun and to keep it centered on the patient. The Consortium will also need to continue to work with providers, patients, and patient organizations.

Reaching other audiences individually and collectively: Many stated that a dedicated effort needed to take place first to share the progress of the Integrated Patient Safety Action Plan internally, and then engage a broader audience.

Next Steps

Overall, the meeting was a good opportunity for participants to reconnect and hear from Lead organizations, particularly lessons learned and the value of partnership and collaboration. The Consortium was pleased to hear about the Never Events list as an output from the Consortium action plan, yet there is more work to be done with the delivery system on this and other actions. Many organizations are committed to the work, but need more clarity on roles as we go forward. Ongoing communication is essential and more information will be needed on what and who to communicate and engage with as the Integrated Patient Safety Action Plan progresses.

"This is going to truly transform how we deliver health care in Canada…we are tired of just talking about it we want to get bold and do things."

Some remaining questions are:

- Who will be the champions for this work and, who will carry the messages?
- How will this work link to the front line and healthcare executives?

The next steps for the Consortium participants are:

1. You can build momentum by:
    - Tell the story of the great work you are involved in by using the communication products within your organization, on your website, and through your existing networks:
        a. **Infographic Video: Patient Safety is our collective responsibility**
        b. **Integrated Patient Safety Action Plan video**
        c. Strategic Communications Plan (provided in meeting materials)
        d. Stakeholder Toolkit (provided in meeting materials)
2. Lead/Co-lead/Partner organizations continue to advance the Integrated Patient Safety Action Plan.
3. Provide any feedback to **nationalconsortium@cpsi-icsp.ca.**

The next steps for CPSI as the coordinating body are to:

1. Continue to work with participants and coordinate the Integrated Patient Safety Action Plan
2. Provide clear and deliberate messaging on how to communicate the work
3. Convene the Evaluation Action Team

APPENDIX A - THIRD NATIONAL PATIENT SAFETY CONSORTIUM MEETING EVALUATION

On September 18, 2015, forty five organizations met for the third meeting of the National Patient Safety Consortium in Toronto. A meeting evaluation was provided to participants at the end of the day. Of the 45 organizations, 25 individuals completed a meeting evaluation (56%). The key findings are summarized below.

Meeting Objectives

- The first five 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	Did Not Answer
Provide a report back to the National Patient Safety Consortium on progress of actions to date	100%	0	0	0
Advance the Integrated Patient Safety Action Plan	80%	20%	0	0
Discuss an evaluation approach for the Consortium and Integrated Patient Safety Action Plan	80%	20%	0	0
Engage Consortium participants in the Integrated Patient Safety Action Plan and revitalize engagement and collaboration	80%	20%	0	0
Overall the objectives of today were achieved.	92%	8%	0	0

APPENDIX A - THIRD NATIONAL PATIENT SAFETY CONSORTIUM MEETING EVALUATION

Meeting Materials and Facilitator

- 88% either strongly agreed or agreed that the “pre meeting materials were clear and helped me prepare for the meeting.” 8% disagreed with the statement and 4% did not answer.
- 100% either strongly agreed or agreed that the facilitator was well organized.
- 92% either strongly agreed or agreed that the “facilitator made good use of the time allocated”. 8% neither agreed nor disagreed with the statement.
- 80% either strongly agreed or agreed that “sufficient time was allowed for audience participation and discussion.” 16% neither agreed nor disagreed, and 4% did not answer.

Meeting Facilities

- The majority of respondents ranked the following meeting facilitates as good or excellent: Sheraton Gateway Hotel (68%), Catering (78%), Audio (56%), and Visuals (72%).

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 Consortium?
   - Engagement of front line staff, physicians and leaders
   - Clarity on roles of each Consortium member and deliverables
   - Aboriginal care, ambulatory and primary care
   - Indicators in the evaluation plan

2. What was the most meaningful/valuable part of the day from your perspective?
   - Live polling
   - Progress on actions to date
   - Networking, small table discussions, afternoon of meeting
   - Presentation by Dr. David Naylor
   - Re-energizing the action plan

3. What was the least meaningful/valuable part of the day from your perspective?
   - Repeating information already found in meeting package (such as some progress updates)

4. What is the next most critical step to ensure that the work of today’s meeting further advances an Integrated Patient Safety Action Plan?
   - Communication, engagement, and involvement of local organizations
   - Regular communication with all stakeholders
   - Clarity on how to evaluate progress, what/how to share information with own organization
   - Include service providers on action teams
   - Continue the momentum going forward

5. Any other feedback/additional comments?
   - Review actions to see which will have the largest impact and consider external validation
   - Allow more time for networking
   - Go digital with meeting materials
   - Some of the afternoon discussions were unclear
   - Evaluation presentation could have focused on baseline measures
   - All was good, but morning could have been more interactive

APPENDIX B - ATTENDEES OF NATIONAL PATIENT SAFETY CONSORTIUM MEETING (SEPTEMBER 18, 2015)

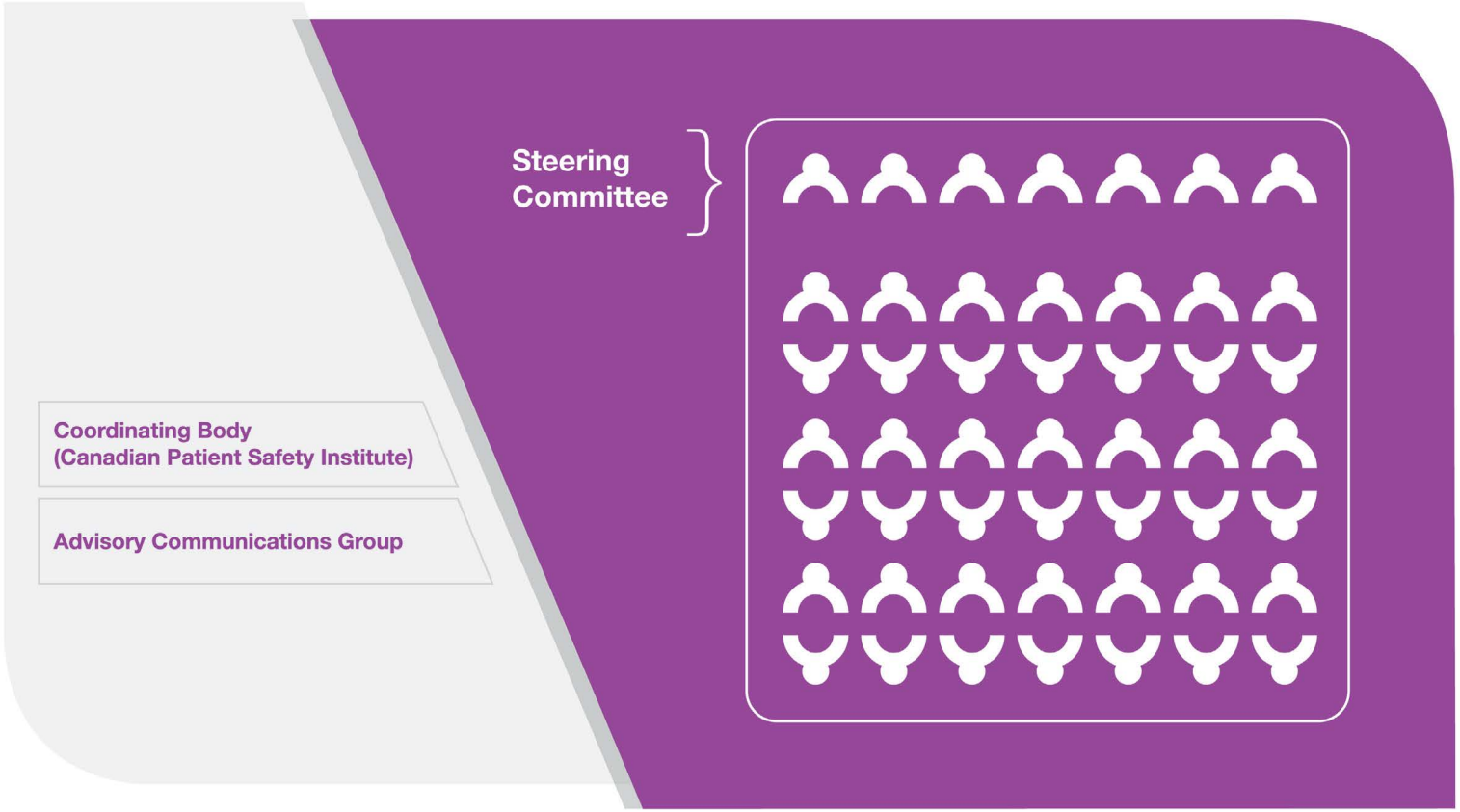
Academy of Canadian Executive Nurses
Accreditation Canada
Alberta Health Services
Association of Faculties of Medicine of Canada
Association of Faculties of Pharmacy of Canada
Atlantic Health Quality and Patient Safety Collaborative
British Columbia Patient Safety and Quality Council
Canada Health Infoway
Canadian Agency for Drugs and Technologies in Health
Canadian Association of Paediatric Health Centres
Canadian Association of Schools of Nursing
Canadian College of Health Leaders
Canadian Foundation for Healthcare Improvement
Canadian Home Care Association
Canadian Institute for Health Information
Canadian Institutes of Health Research
Canadian Medical Protective Association
Canadian Nurses Association
Canadian Nurses Protective Society
Canadian Patient Safety Institute
Canadian Pharmacists Association
Canadian Society of Medical Laboratory Sciences
Health Canada
Health PEI
Health Quality Council of Alberta
Health Quality Ontario
Healthcare Insurance Reciprocal of Canada
HealthCare*CAN*
Infection Prevention and Control Canada
ISMP Canada
Manitoba Institute for Patient Safety
Mental Health Commission of Canada
Ministry, Alberta Health
Ministry, New Brunswick Health
Ministry, Newfoundland Department of Health and Community Services
Ministry, Nova Scotia Department of Health and Wellness
Ministry, Saskatchewan Health
New Brunswick Health Council
Newfoundland Labrador Quality, Patient Safety Provincial Committee
Ontario Hospital Association
Patients Canada
Patients for Patient Safety Canada
Public Health Agency of Canada
Royal College of Physicians and Surgeons of Canada
The College of Family Physicians of Canada

* The Government of Quebec did not attend the National Patient Safety Consortium meeting.

APPENDIX C - GOVERNANCE STRUCTURE OF THE NATIONAL PATIENT SAFETY CONSORTIUM

NATIONAL PATIENT SAFETY CONSORTIUM

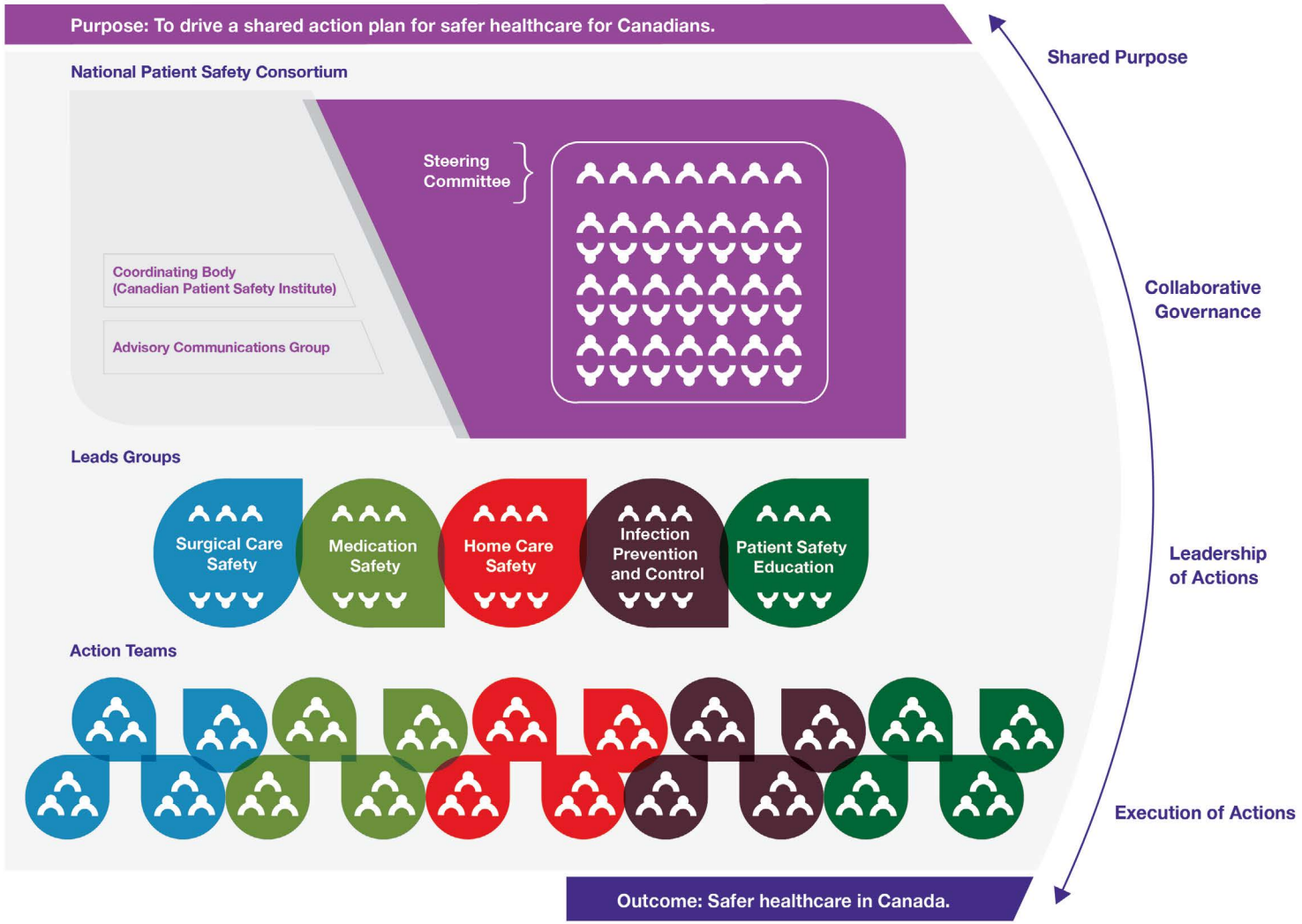
Purpose: To drive a shared action plan for safer healthcare for Canadians.



Outcome: Safer healthcare in Canada.

APPENDIX C - GOVERNANCE STRUCTURE OF THE NATIONAL PATIENT SAFETY CONSORTIUM

STRUCTURE AND PROCESS TO SUPPORT THE INTEGRATED PATIENT SAFETY ACTION PLAN



APPENDIX D - STEERING COMMITTEE AND LEAD GROUP MEMBERS

National Patient Safety Consortium Steering Committee Members

Name	Organization/Representative
Wendy Nicklin, President and CEO	Accreditation Canada
Verna Yiu, Vice President Quality & Chief Medical Officer	Alberta Health Services
Jennifer Zelmer, Executive Vice President	Canada Health Infoway
David O'Toole, President and CEO	Canadian Institute for Health Information
Chris Power, CEO and Chair of Steering Committee	Canadian Patient Safety Institute
Nancy Roberts, Executive Director of Program Integration and Performance	Department of Health, New Brunswick
Lee Fairclough, VP, Quality Improvement	Health Quality Ontario
Sharon Nettleton, Co-Chair (of PFPSC)	Patients for Patient Safety Canada (PFPSC)
Denice Klavano, Co-Chair (of PFPSC)	Patients for Patient Safety Canada (PFPSC)

**** As the coordinating body of the National Patient Safety Consortium, CPSI will provide meeting support for the Steering Committee.***

APPENDIX D - STEERING COMMITTEE AND LEAD GROUP MEMBERS

Surgical Care Safety Leads Group

Name	Organization/Representative
Cindy Hollister	Canada Health Infoway
Claude Laflamme	Canadian Anesthesiologists' Society
Lorraine LeGrand Westfall	Canadian Medical Protective Association
Sandi Kossey, Carla Williams, Jennifer Rodgers	Canadian Patient Safety Institute
Arlene Kraft	Healthcare Insurance Reciprocal of Canada
Bonnie McLeod	Operating Room Nurses Association of Canada
Kapka Petrov	Patients for Patient Safety Canada
Donna Davis	Patients for Patient Safety Canada

APPENDIX D - STEERING COMMITTEE AND LEAD GROUP MEMBERS

Medication Safety Leads Group

Name	Organization/Representative
Maureen Charlebois	Canada Health Infoway
Jordan Hunt	Canadian Institute for Health Information
Sandi Kossey, Stephen Routledge, Mike Cass	Canadian Patient Safety Institute
Margaret Zimmermann	Health Canada (Makreted Health Products Directorate)
David U	Institute for Safe Medication Practices Canada
Johanna Trimble	Patients for Patient Safety Canada
Linda Hughes	Patients for Patient Safety Canada

APPENDIX D - STEERING COMMITTEE AND LEAD GROUP MEMBERS

Home Care Safety Leads Group

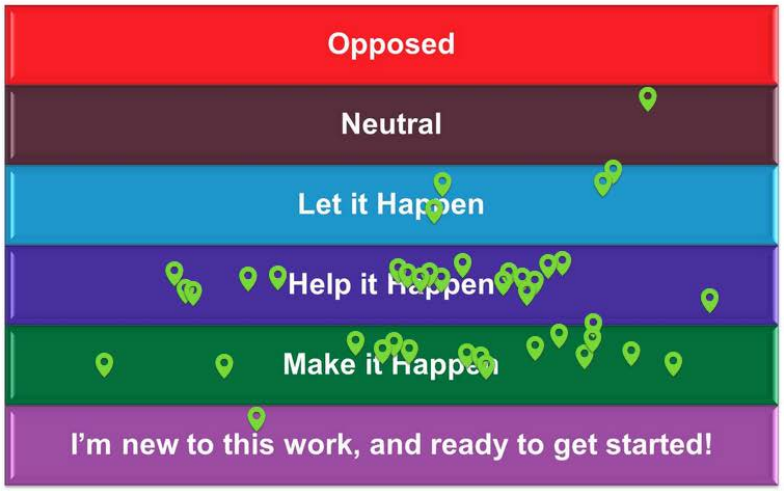
Name	Organization/Representative
Nadine Henningsen	Canadian Home Care Association
Adrian Dalloo	Canadian Institute for Health Information
Nancy Lefebre	Saint Elizabeth
Anne Lyddiatt	Patients for Patient Safety Canada
Barb Farlow	Patients for Patient Safety Canada
Additional Provider to be Named	
Kim Stelmacovich, Joan Fernandez, Wayne Miller	Canadian Patient Safety Institute

APPENDIX D - STEERING COMMITTEE AND LEAD GROUP MEMBERS

Patient Safety Education Leads Group

Name	Organization/Representative
Dale Shierbeck	HealthCare*CAN*
Deborah Prowse	Patients for Patient Safety Canada
Deborah Tregunno	Queen's University
Donna Davis	Patients for Patient Safety Canada
Dr. Gord Wallace	Canadian medical Protective Association
Dr. Ross Baker	University of Toronto
Dr. Ward Flemons	University of Calgary
Margot Harvie	Health Quality Council of Alberta
Maryanne D'Arpino, Dannie Currie	Canadian Patient Safety Institute
Ray Racette	Canadian College of Health Leaders
Tim Willett	SIM - one

Where is your organization currently with respect to commitment to the Integrated Patient Safety Action Plan?



Total Results: 41

Where is your organization on the Collaboration Spectrum for the National Patient Safety Consortium?

Respond at **PollEv.com/forwardwith4**

Total Results: 24

Which best describes the current state of your organization with respect to the INTEGRATED PATIENT SAFETY ACTION PLAN?

Total Results: 27