Canada’s Forum on Patient Safety and Quality Improvement 2010

Improving Safety Across the Continuum

Concurrent Sessions Guide

April 12-14, 2010 - Toronto, ON
Westin Harbour Castle

Register Now! www.eplyevents.com/cpsi2010
Concurrent Sessions Guide

This program is subject to change. Please visit the registration site often for updates to the program and other Forum materials at www.eplyevents.com/cpsi2010 or feel free to visit us directly at www.patientsafetyinstitute.ca regularly for updates.

All concurrent sessions will be conducted in English.

The streams for the Forum will fall under the following areas:

- Building Skills in Quality & Safety
- Infection Prevention & Control
- Medication Safety
- Partnering for Patient Safety
- Learning from Adverse Events
- Building a Culture of Quality & Safety

Tuesday, April 13, 2010 - 9:30am – 10:30am
Concurrent Sessions A

A: Building Skills in Quality & Safety: Room A

Leading the Next Stage of Healthcare Improvement

Jim Easton, National Director for Improvement and Efficiency, National Health Service, UK

**This is a 2 session workshop – Concurrent Session A and B**

This workshop will address three questions on leading for quality:
1. How do we need to develop ourselves as healthcare improvement leaders?
2. How do we change the culture of the places we work to drive for quality?
3. How can we make our teams improvement teams?

Participants of this workshop will learn the fundamentals for leading quality improvement.
A: Building Skills in Quality & Safety: Room B

The Human Factor - The Critical Importance of Effective Teamwork and Communication Across the Continuum

Michael Leonard, MD, Principal, Pascal Metrics Inc.

**This is a 2 session workshop – Concurrent Session A and B**

The objective of this workshop is to have participants appreciate how communication failures are at the root cause of the overwhelming majority of unanticipated adverse events in medical care, learn SBAR, an effective situational briefing model, to enhance effective communication and understand the critical importance of Assertion / Critical Language, so providers can speak up reliably when they perceive risk to a patient.

Participants of this workshop will learn the fundamentals of teamwork and communication for improved patient safety.

A: Infection Prevention & Control

Striving for the Possible: Zero Catheter-Related Blood Stream Infections

Dr. William Jarvis, Deputy Editor of “Infection Control and Hospital Epidemiology,” former President of the Society of Healthcare Epidemiology of America, and Vice-President and Member of the APIC Research Foundation Board of Directors

Description to be provided shortly

A: Medication Safety

Effects of Interruptions on Drug Administration Performance

Tara McCurdie, Human Factors Analyst, Healthcare Human Factors, Centre for Global eHealth Innovation, University Health Network

Distractions and interruptions have been identified as frequent contributors to medication errors and the resultant harm. The goal of this research was to examine the effects of interruptions on routine high-risk procedures involved in delivery of chemotherapy regimens.

Participants of this session will learn about the effects of interruptions on routine high-risk procedures involved in delivery of chemotherapy regimens.

A Novel Approach in Improving the Quality of Postoperative Patient Controlled Analgesia

Conor McDonnell, Staff Paediatric Anaesthesiologist, Hospital for Sick Children

This presentation will describe current problems with opioids and PCAs in pediatric surgical and medical practice; describe an alternate focus towards improving opioid safety i.e. minimize demand for opioids; and report the development of a novel approach to improving the way we deliver postoperative analgesia with PCA opioids.

Participants of this session will learn about improving opioid and PCA use in pediatric surgery.
A: Partnering for Patient Safety

Developing Safety Collaboration in the Community Sector

Dorothea Bailey-Leung, Service Quality Specialist, Toronto Central Community Care Access Centre (CCAC)

Kristen Caballero, Quality Assurance Health Services Manager, Calea Ltd.

By sharing benefits, challenges, and lessons learned, the Toronto Central CCAC will provide valuable insight on how organizations in a managed competition environment can work together to improve client and staff safety. Particularly, this presentation will provide Quality and Risk Managers with strategies on how to build a collaborative safety program across the community sector. This presentation will describe the development of a truly collaborative advisory group between the Toronto Central CCAC and Contracted Service Providers of the CCAC. Discussion topics include the development of the Client and Staff Safety Collaborative - challenges and successes, functions of the committee, strategic and operational plan, key indicators of safety initiatives lead by the advisory committee. As well, methods on how to create a culture of safety between disciplines and organizations will be examined.

A: Learning from Adverse Events

Understanding the Medico-Legal Framework for Quality Improvement: Part 1

Dr. Susan Swiggum, Senior Physician Risk Manager, Canadian Medical Protective Association

Dr. Gordon Wallace, Director of Education, Canadian Medical Protective Association

**This is a 2 session workshop – Concurrent Session A and B**

A cornerstone of modern patient safety is the creation of a workplace that encourages the reporting of adverse events and close calls, analyses these fairly, and thus corrects vulnerabilities. These “hands-on” linked sessions explore the role of structured quality improvement review in Canada, and how to find the right balance between helping all health professionals provide safer care, while fairly addressing any issues of individual performance and accountability. Part 1 of 2 parts.

Participants of this workshop will be able to list 3 elements of a “just culture of patient safety”, and describe a medico-legal framework for learning from adverse events and close calls.

A: Building a Culture of Quality & Safety

The 2009 Canadian Health Accreditation Report: Implications for Enhancing Quality and Strengthening Patient Safety

Jonathan Mitchell, Lead, Accreditation Program Development, Accreditation Canada

Christopher Dean, Quality Assessor, Quality, Risk & Evaluation, Accreditation Canada

National Accreditation results for Required Organizational Practices (ROPs) and patient safety culture survey will be presented.

Participants of this session will learn about patient safety areas where Canadian healthcare settings are excelling, gaps that require action, and ideas for quality improvement and strengthening patient safety.
Tuesday, April 13, 2010 - 10:50am – 12:00pm
Concurrent Sessions B

B: Building Skills in Quality & Safety: Room A

Leadership for Safety and Quality Improvement
Jim Easton, National Director for Improvement and Efficiency, National Health Service, UK

**This is a 2 session workshop – Continuation of Session A**

This workshop will address three questions on leading for quality:
1. How do we need to develop ourselves as healthcare improvement leaders?
2. How do we change the culture of the places we work to drive for quality?
3. How can we make our teams improvement teams?

Participants of this workshop will learn the fundamentals for leading quality improvement.

B: Building Skills in Quality & Safety: Room B

The Human Factor - The Critical Importance of Effective Teamwork and Communication Across the Continuum
Michael Leonard, MD, Principal, Pascal Metrics Inc.

**This is a 2 session workshop – Continuation of Session A**

The objective of this workshop is to have participants appreciate how communication failures are at the root cause of the overwhelming majority of unanticipated adverse events in medical care, learn SBAR, an effective situational briefing model, to enhance effective communication and understand the critical importance of Assertion / Critical Language, so providers can speak up reliably when they perceive risk to a patient.

Participants of this workshop will learn the fundamentals of teamwork and communication for improved patient safety.

B: Infection Prevention & Control

Feedback as a Tool in Improving Staff Compliance with Infection Prevention and Control
Craig Pienkowski, Infection Control Practitioner, Providence Health Care

In an effort to enhance communication between Infection Prevention and Control (IPAC) and each acute inpatient unit, a specific ‘Feedback Board’ was created. This board displays the number of case(s) of transmission of specific organisms, hand hygiene rates and important notices, complying with Accreditation Canada’s required organizational practice.

Participants of this session will learn about one way to improve communication and feedback for improved infection control.
B: Medication Safety

Capacity Building and Sustainability in Medication Quality and Safety: Constructing a Framework of Workforce Culture and Clinical Skills that Optimize Patient Safety

Corey Ralph, Provincial Manager, Medication Quality and Safety, Alberta Health Services - Pharmacy Services

As healthcare providers and managers we continually explore methods to improve the outcomes for our patients.

Participants of this session will learn the fundamentals of the capacity building and sustainability model and how healthcare systems can use the model to optimize the development, implementation and evaluation of quality and safety initiatives.

Improving the Safety of Ambulatory Chemotherapy in Canada: Collaborating with Graphic Designers to Improve Pre-Printed Orders

Jennifer Jeon, Human Factors Analyst, Healthcare Human Factors Group

The objective of this study is to improve patient safety by collaborating with clinicians, human factors experts and graphic designers to develop a guideline for improving pre-printed chemotherapy orders.

Participants of this session will learn how graphic design can influence the safety of pre-printed chemotherapy orders.

B: Partnering for Patient Safety

Homecare: What is Currently Happening in this Challenging Environment?

Dr. Marilyn Macdonald, Assistant Professor; Dalhousie University

Members of the Canadian Patient Safety Institute (CPSI) Core Safety in Home Care Team conducted an environmental scan of the state of knowledge regarding safety in homecare in Canada.

Participants of this session will learn about the current state of knowledge about patient safety in Canada.

Safety in Palliative Homecare: A Partnership of Perspectives

Dr. Ariella Lang, Research Scientist; VON Canada

The purpose of this study is to explore experiences, challenges, and insights regarding the safety of those receiving and providing palliative homecare services in Quebec urban settings.
B: Learning from Adverse Events

Applying a Medico-Legal Framework to Quality Improvement: Part 2
Dr. Susan Swiggum, Senior Physician Risk Manager, Canadian Medical Protective Association
Dr. Gordon Wallace, Director of Education, Canadian Medical Protective Association

**This is a 2 session workshop – Continuation of Session A**
Participants of this workshop, using the medico-legal framework and approaches provided in Part 1, will work through real case scenarios of unexpected outcomes and adverse events.

B: Building a Culture of Quality & Safety

Introducing Patient Safety and Quality Content into University Curriculum
Hilary Espezel, Director, Evaluation & Special Projects, Provincial Health Services Authority

With an increased focus on patient safety and nurses comprising the largest healthcare workforce sector, nursing students require conceptual and practical experience. This presentation will present an academic-practice partnership that has raised students’ awareness of patient safety and increased the commitment to a culture of safety in practice settings.

Participants of this session will learn one way to engage nursing students in patient safety.

See, Touch and Be a Part of the Quality Culture Quest
Teresa Smith, Assistant Vice-President, Quality, Patient Safety, Clinical Resource Management and Pharmaceutical Services, Hamilton Health Sciences

Participants of this session will learn how to strategically develop a Quality Framework.

Teaching 10,000 to Fish
Sharon Pierson, Director, Hamilton Health Sciences

Participants of this session will learn about the use of Patient Safety Triads (Sibald Award Winners) & other educational musts.
C: Building Skills in Quality & Safety: Room A

An Adaptable Methodology for Integrating Quality Improvement Curriculum into Undergraduate Health Sciences Education

Taylor Bassingthwaite, Quality Improvement Consultant, Saskatchewan Health Quality Council

Through integrating quality improvement (QI) concepts into undergraduate training we increase the capability of future providers to lead QI initiatives. The Health Quality Council developed QI curriculum for the 2008/2009 academic year that was disseminated to students at the University of Saskatchewan. Participating disciplines included: Nutrition, Pharmacy, Medicine, Physiotherapy and Public Health.

Participants of this session will learn about an inter-professional health sciences QI curriculum.

C: Building Skills in Quality & Safety: Room B

What's Ethics Got to Do With It?: Practical Approaches to Managing Ethical Risk in Quality Improvement and Evaluation Projects

Linda Barrett-Smith, Manager, Research Ethics Initiatives, Alberta Heritage Foundation for Medical Research

This session uses a ‘hands-on’ approach to introduce two practical ethics decision-support tools that help leaders of quality improvement (QI) and evaluation initiatives identify and manage ethical risk in their projects.

Participants of this session will learn one way to identify and manage ethical risk in projects.

C: Infection Prevention & Control

Implementing a Safer Infection Prevention Program for Construction Projects

Gordon Burrill, Vice-Chair, Technical Committee, Healthcare Facility Engineering & Physical Plant, Canadian Standards Association

The session will examine different strategies employed by Canadian health care facilities to minimize the risks of infection originating from construction, renovation, maintenance and repair sites. Focus will be on the content of the Canadian standard that governs special requirements that must be undertaken to protect vulnerable building occupants from pathogens created throughout the construction process.

Participants of this session will learn about how to prevent infections from facility construction processes.
C: Medication Safety

Improving the Safety of Ambulatory Intravenous Chemotherapy in Canada: A study Overview

Rachel White, Human Factors Specialist, Healthcare Human Factors Group

The objectives of this 20-month study were to identify safety issues in ambulatory intravenous chemotherapy in a wide range of environments across Canada, and to make associated recommendations for safety improvements.

Participants of this session will learn about recommendations for the safe provision of ambulatory chemotherapy.

The Medication Safety Game Online: An Innovative Approach to Patient Safety

Prabhjot Gill, Regional Coordinator, Clinical Orientation Program, Vancouver Coastal Health
Linda Dempster, Regional Director, Quality & Patient Safety, Vancouver Coastal Health

Promoting a culture of safety is a key strategic initiative in most health care organizations. Medication safety is one important aspect of this safety culture. Medication use in hospitals is complex and susceptible to errors at multiple points. Common medication errors occur due to look alike sound alike drug names, dosage miscalculations, illegible handwriting and distractions.

Participants of this session will learn how to improve medical safety through innovation means.

C: Partnering for Patient Safety

Through the Patients Eyes ... User Involvement and Leadership: A Breakthrough and Driver for Quality Improvement

Anders Vege, Head of Section for Quality Improvement, Norwegian Knowledge Centre for the Health Services

This presentation will share learning from a Norwegian National Breakthrough Series (BTS) Collaborative focusing on user involvement, leadership and transformation of services. The Collaborative involved those from both primary and secondary health care services.

Participants of this session will learn: a) how to get health care leaders on board with patients and family engagement, including the success criteria; b) the use of dialogue conferences and other strategies to raise the patients voice; c) how user involvement and quality improvement were addressed at the same time; and d) how spread was supported through the Collaborative.
C: Learning from Adverse Events

Success Stories I: Learning from Adverse Events
In recent years, health care organizations are improving the identification of adverse events and focusing on system improvements to prevent reoccurrences. Learn from those who have done it! A panel discussion will follow the presentations and answer questions from the audience.
Participants of this session will learn about case experiences of the identification and preventative response to adverse events.

Improving Patient Safety by Analyzing Critical Incidents Using a Multi-Disciplinary Approach
Lianne Dzygala, Risk Management Advisor, Jewish General Hospital
Lynne McVey, Director of Nursing, Associate Professor, School of Nursing, McGill University
This university teaching hospital has been actively working on its Critical Incident Review (CIR) process for five years. Their goal is to promote a just and safe patient culture without blame.
Participants of this session will learn about how inter-professional CIRs can improve patient safety.

A practical Example of the Use of Root Cause Analysis in a Radiation Therapy Department
Gaylene Medlam, Supervisor, Radiation Therapy, Peel Regional Cancer Centre, Credit Valley Hospital
By coming together as a team to discuss an adverse event, a potentially negative experience became a positive one. The London Protocol helped understand the real issues and develop real solutions.
Participants of this session will learn how one hospital uses RCAs to improve patient safety.

Analysis and Themes in Recommendations Resulting From Quality Assurance (QA) Reviews
Kathryn Bush, Clinical Safety Leader, Alberta Health Services
Investigation into adverse events, hazards and close calls using QA reviews helps identify system gaps and often results in recommendations to improve patient safety. This group looked at QA recommendations and their subsequent implementation.
Participants of this session will learn how QA reviews can improve patient safety on a systems level.
C: Building a Culture of Quality & Safety

Lessons Learned from High Performing Health Organizations

Dan Horvat, Assistant Professor; Co-Lead, Primary Health Care, Northern Medical Program, UBC; Northern Health

Results from June 2009 Consensus Meeting in Vancouver inclusive of Care Oregon, Intermountain Health (Utah), Jonkoping County (Sweden), UK NHS, South Central Foundation (Alaska) Leaders. Participants of this session will learn to identify enablers of sustainable and highly effective health care organizations and systems; and better understanding of ways to use the enablers in your organizations and systems.

Wednesday, April 14, 2010 - 9:25am – 10:25am
Concurrent Sessions F

F: Building Skills in Quality & Safety: Room A

Moving from Evidence-Based Medicine to Evidence-Based Care Delivery

Jason Leitch, National Clinical Lead for Safety and Improvement, Scottish Government Health Foundation/Institute for Healthcare Improvement Fellow

It takes nearly twenty years to deliver 14% of the evidence we discover into frontline care. The challenge for the next decade is to close the loop between discovery and implementation. This presentation will outline the challenge and how we ended up in this position. It will then discuss possible solutions. Applying concepts such as ‘bundles’ can lead to process improvement in healthcare delivery and if linked to the evidence can also therefore produce improved outcomes.

Participants of this session will learn about strategies for evidence based care.

F: Building Skills in Quality & Safety: Room B

Teamwork

Réné Lalumiére, President, Safety Training Services Inc.

The purpose of this session is to demonstrate the importance of teamwork in healthcare; where several specialties coordinate to ensure patient safety. Interpersonal skills are essential in establishing and maintaining positive communication between departments and the patient.

Participants of this session will learn the characteristics of an efficient team where leadership is shared and centered on the patient, the key information provider.
F: Infection Prevention & Control

**Developing an Antimicrobial Stewardship Program**

**Andrew Morris**, Director, Antimicrobial Stewardship Program, Mount Sinai Hospital/University Health Network

Participants of this session will learn how to develop and implement an antimicrobial stewardship program in their institution.

F: Medication Safety

**Smart Pumps: Maximizing their Impact on Medication Safety**

**Sonia Pinkney**, Human Factors Analyst, Healthcare Human Factors, Centre for Global eHealth Innovation, University Health Network

**Anthony Easty**, PhD., PEng, CCE, Chair, Management Committee, Centre for Global eHealth Innovation, Associate Professor, University of Toronto, Senior Director, Medical Engineering, University Health Network

Smart pumps were developed to help reduce intravenous medication errors by alerting users to potential programming errors. However, smart pumps can cost four times more than traditional pumps without significantly improving medication safety.

Participants of this session will learn evidence-based skills to optimize smart pump implementation.

F: Partnering for Patient Safety

**Improving Suicide Risk Assessment Across the Continuum in an Inner City Mental Health Service**

**Nicole Kirwan**, Clinical Nurse Specialist, St. Michael’s Hospital

This presentation will describe a quality improvement initiative undertaken by a large inner city Mental Health Service to improve suicide risk assessment across the continuum of hospital and community-based mental health services provided for seriously and persistently mentally ill individuals.

Participants of this session will learn skills to improve suicide risk assessment.
F: Learning from Adverse Events

Success Stories II: Learning From Adverse Events

In recent years, health care organizations are improving the identification of adverse events and focusing on system improvements to prevent reoccurrences. Learn from those who have done it! A panel discussion will follow the presentations and answer questions from the audience.

Participants of this session will learn about case experiences of the identification and preventative response to adverse events.

An Adverse Event in Long-Term Care: A Moment in Time

Nina Labun, Clinical Nurse Specialist, Revera Long Term Care

Jennifer Harwood, Revera Long Term Care

This group shares how they learned from a significant adverse medication event in a long-term care setting. Medication safety in long-term care remains a challenge given the complexity of conditions under which medication administration occurs and the continued underreporting of medication errors (Vogelsmeier, Scott-Cawiezell, & Zellmer, 2007).

Participants of this session will learn the positive outcomes learned from a significant adverse medication incident in a long-term care setting.

Accelerating to Zero Preventable Deaths

Sharon Pierson, Director Quality, Patient Safety & Clinical Resource Management, Hamilton Health Sciences (HHS)

Participants of this session will learn about how an interdisciplinary Death & Adverse Event Review process supports continuous improvements in care.

Critical patient alert: emergency laboratory notification

Alissa Howe-Poisson, Clinical Practice Manager - Family Birthing Center, Windsor Regional Hospital

Participants of this session will learn about one hospital’s experience after caring for a patient with a post partum haemorrhage, the need for a more coordinated team effort with effective communication and improved response time was recognized. The Critical Patient Alert response resulted.
F: Building a Culture of Quality and Safety

From Boardrooms to Points of Care: Safety Culture Building Blocks
Linda Hunter, Director, Quality and Patient Safety, The Ottawa Hospital
Barbara Trerise, Vice President, Patient Safety, Quality and Information Management, Providence Health Care
Lisa Ruston, Corporate Director Surgical Services & Quality Lead, Peterborough Regional Health Centre

Participants of this session will examine the values, strategic actions, supports, lessons learned and infrastructure requirements for building a Culture of Safety; and to examine measures of success.

Wednesday, April 14, 2010 - 1:00pm – 2:00pm
Concurrent Sessions D

D: Building Skills in Quality & Safety: Room A

Breakthrough series focusing on both quality improvement and users involvement:
A presentation of tools and techniques
Anders Vege, Head of Section for Quality Improvement, Norwegian Knowledge Centre for the Health Services

**This is a 2 session workshop – Concurrent Session D and E**

A presentation of a Norwegian National Breakthrough Series (BTS) involving different primary and secondary health care services. The main focus was user involvement, leadership and transformation of services. The workshop will present strategies and tools from the BTS in a systematic approach. It will also contain interactive components with both testing out some of the tools for use in your own organisation and reflection on the issue users involvement. The workshop will challenge on questions such as how to get leaders on board and commit them and users involvement as a driver for quality improvement.

Participants of this workshop will learn the tools needed to involve users and leaders in the transformation of services.
**D: Building Skills in Quality & Safety: Room B**

**Human Factors 101: Designing Safety into Healthcare Systems**

Rachel White, Human Factors Specialist, Healthcare Human Factors

**This is a 2 session workshop – Concurrent Session D and E**

This two session series is for healthcare professionals who are new to patient safety and/or human factors.

Participants of this workshop will learn to define human factors for the healthcare context; provide a systems view of risk and adverse events; and fell empowered to make healthcare safer.

**D: Infection Prevention & Control**

**Reducing Antimicrobial Resistance in an ICU Through Antimicrobial Stewardship**

Andrew Morris, Director, Antimicrobial Stewardship Program, Mount Sinai Hospital/University Health Network

In February 2009, Mount Sinai Hospital started its antimicrobial stewardship program with audit-and-feedback of antimicrobials in the ICU.

Participants of this session will learn the process involved in performing antimicrobial stewardship in the ICU.

**An Antimicrobial Stewardship Program’s Quality & Safety Initiative Aimed at Antibiotic Prophylaxis for Caesarean Sections**

Sandra Howie, Antimicrobial Stewardship Pharmacist, Mount Sinai Hospital

An Antimicrobial Stewardship Program (ASP) aimed to decrease the rate of post-caesarean section surgical site infections and endometritis at an acute care teaching hospital by implementing a change in practice to the timing and type of antibiotic prophylaxis.

Participants of this session will learn the process by which one hospital focused on Antimicrobial Stewardship regarding timing and type of antibiotic prophylaxis.
D: Medication Safety

Failure Mode Effects Analysis (FMEA) for Morphine Prescribing Practices

Hilary Writer, Children’s Hospital of Eastern Ontario

Kris Gustavson, Corporate Director, Accreditation & Patient Experience, Provincial Health Services Authority

The aim of this study is to identify and prioritize potential failures during the morphine prescribing process through the conduct of an FMEA. To the authors’ knowledge, the potential failures that may occur during morphine prescribing have never been evaluated at any pediatric hospital in Canada.

Participants of this session will learn about improving morphine safety using FMEA.

Medication Safety in the Home: Lock it Up!

Jillian Bates, Quality Leader, The Hospital For Sick Children

Participants of this session will learn about the medication safety initiative ‘Lock-it-Up!’ which is aimed to prevent injury in children from unintentional ingestion of chemotherapy at home, and to have families with children six years and under lock-up their medications.

D: Partnering for Patient Safety

Creating Compelling Content – A Strategic Approach to New Media

Rahaf Harfoush, New Media Expert, Member of President Barack Obama’s Social Media Team

Objective: To familiarize users with existing platforms and provide practical tips to be able to identify and act upon opportunities to create great content.

Topics Covered:

1. The Tools: A basic overview of Facebook, Linked in and Twitter.
2. Creating Content: Plan Design and Create. How to formulate an easy to follow plan once you’ve decided to create content.
3. Sharing the Content: Using social channels to spread your message.
4. Responding to Content: Building community by understanding online relationships, building trust and providing value.
5. Case studies: some examples of things that have worked, and things that haven’t.

D: Learning from Adverse Events

Learning From the Dead: A Coroner’s Perspective

Andrew McCallum, M.D. FRCP, Chief Coroner for Ontario

An experienced coroner (medical examiner) provides his insight into how adverse events happen and what can be done to limit their likelihood.

Participants of this session will be able to describe the role and responsibilities of a coroner (medical examiner) in Canada and describe 3 common reasons for adverse events and possible solutions.
D: Building a Culture of Quality and Safety

Canadian Patients and Primary Care Physician Perspectives on Quality and Safety Issues: 2008-2009 Commonwealth Fund International Health Policy Survey Results

Dr. Kent Campbell, Senior Health Systems Analyst, Health Council of Canada

Participants of this session will learn to appreciate the survey findings and where patient and physician perceptions overlap and vary: explore the potential value of electronic health record in improving quality and safety: and to assess suggested health system changes the study revealed.

What Liability Might Governments Have in the Future for Patient Safety?

Lorian Hardcastle, University of Toronto

Participants of this session will be able to explore the correlation between system level factors that contribute to harm and liability practices to date; and whether government liability might change patient safety outcomes and how.

Wednesday, April 14, 2010 - 2:30pm – 3:30pm

Concurrent Sessions E

E: Building Skills in Quality & Safety: Room A

Breakthrough series focusing on both quality improvement and users involvement:
A presentation of tools and techniques

Anders Vege, Head of Section for Quality Improvement, Norwegian Knowledge Centre for the Health Services

**This is a 2 session workshop – Continuation of Session D**

A presentation of a Norwegian National Breakthrough Series (BTS) involving different primary and secondary health care services. The main focus was user involvement, leadership and transformation of services. The workshop will present strategies and tools from the BTS in a systematic approach. It will also contain interactive components with both testing out some of the tools for use in your own organisation and reflection on the issue users involvement. The workshop will challenge on questions such as how to get leaders on board and commit them and users involvement as a driver for quality improvement.

Participants of this workshop will learn the tools needed to involve users and leaders in the transformation of services.
E: Building Skills in Quality & Safety: Room B

Human Factors 101: Designing Safety into Healthcare Systems
Rachel White, Human Factors Specialist, Healthcare Human Factors

**This is a 2 session workshop – Continuation of Session D**

This two session series is for healthcare professionals who are new to patient safety and/or human factors.

Participants of this workshop will learn to be able to define human factors for the healthcare context; provide a systems view of risk and adverse events; and feel empowered to make healthcare safer.

E: Infection Prevention & Control

Exploring the Key Challenges in Hand Hygiene in an Ambulatory Care O.R. Setting: Does staged education improve compliance?
Sonia Pagura, Director of Quality and Performance, Women's College Hospital

Women's College Hospital is the only stand-alone ambulatory care centre in Ontario. While infection control is pivotal to patient safety, this setting creates unique challenges in maintaining hand hygiene compliance. An education program was developed to address the uniqueness of this setting, and audited to monitor sustained compliance.

Participants of this session will learn about an education program for infection control in a unique setting.

Using ‘Talking Walls’ to Improve Staff Compliance with Hand Hygiene
Wayne Gilbart, Infection Control Practitioner, Providence Health Care

Healthcare associated infections represent an adverse outcome of the hospital visits (Baker et al, 2004). Hand hygiene is important in stopping such infections yet compliance remains poor. Audits using the World Health Organisation’s Five Moments of Hand Hygiene’ carried out at the Providence Health Care (PHC) showed results of around 40% compliance.

Participants of this session will learn about a strategy to improve hand hygiene compliance.

E: Medication Safety

Evaluation of the Impact of a Drug Profile Viewer has on Medication Reconciliation at Transition Points of Care
Olavo Fernandes, PharmD, FCSHP, Clinical Director of Pharmacy, University Health Network, Assistant Professor, Leslie Dan Faculty of Pharmacy, Univ. of Toronto
Cassandra Frazer, RRT, BSc, Clinical Adoption - Benefits Realization & Quality Improvement Leader, Canada Health Infoway

To demonstrate the impact of a drug profile viewer (DPV) system on efficiency, safety and quality of patient care with a specific focus on medication reconciliation (aimed at assuring medication accuracy for patients at transitions in care) and medication discrepancies.

Participants of this session will learn how a drug profile viewer can improve patient safety.
The Applicability of Human Factors Analytical Techniques in Assessing Barriers to Safe Medication Management in the Home

Melissa Griffin, Masters Student, University of Toronto

This presentation will outline the methods and pilot findings of an innovative four province study that uses a multi-disciplinary approach to consider supports and barriers to safe medication management in the home as identified by clients, family members, home care providers, human factors engineering experts, and other key stakeholders.

Participants of this session will learn about support and barriers to safe medication management in the home.

E: Partnering for Patient Safety

Quality and Safety Standards for Primary Care: A Partnership Approach

Lacey Phillips, Research Product Development Specialist, Accreditation Canada

The objectives of this panel presentation are to provide an overview of the new accreditation survey process for Primary Care Services, and how national partners were engaged in developing, pilot testing and approving new standards for primary care. Specific experiences in testing the standards in different provinces will be discussed.

Participants of this session will learn about the new accreditation survey process for Primary Care Services.

E: Learning from Adverse Events

Sharing Learning More Broadly After Adverse Events – Getting the Message Out

Participants will hear of how the need for improvements were or can be identified, and some of the enablers and barriers to making a difference. A panel discussion will follow.

Claire’s story

Vickie Kaminski, President and Chief Executive Officer, Eastern Health

An external review of the death of a young child in a PICU made several recommendations. Learning from what happened, making improvements in the department involved and then the broader health authority are discussed.

Patient Safety in Saskatchewan: Adverse Event Rates and their Cost to the Health Care System

Recep Gezer, Researcher, Saskatchewan Health Quality Council

Participants of this session will learn about that hospital administrative data provides a potentially useful and inexpensive tool to monitor patient safety and about a number of opportunities for improvement.
E: Building a Culture of Quality and Safety

It’s Not Rocket Science - EHS & Lab Strategies:

Medavie EMS Commits to a Culture of Patient Safety

Tom Dobson, Clinical Quality Coordinator, Emergency Health Services Nova Scotia

Adoption of CPSI Safety Competencies Framework in day to day work as a launching pad to build a culture of safety in ambulance services.

Participants of this session will learn one strategy to implement the CPSI Safety Competencies Framework.

Communication of Critical Test Results

Nancy Wylie, Clinical Manager, Quality, Patient Safety & Clinical Resource Management, Hamilton Health Sciences

The goal of the Critical Test Results or Critical Interventions Related to Drug Orders initiative is to improve patient safety by ensuring that life-threatening critical test results are defined, documented and reported to the appropriate care giver in a timely fashion.

MAINTENANCE OF CERTIFICATION:

Attendance at this program entitles certified Canadian College of Health Service Executives members (CHE / Fellow) to 11 Category I credits toward their maintenance of certification requirement.