partnering for patient safety II

workshop program

Thursday, October 19, 2006

0730 – 0830 **Registration and Continental Breakfast** Pavilion Ballroom

0845 – 0900 **Welcome and Opening Remarks** Pavilion Ballroom

Philip Hassen, Chief Executive Officer, Canadian Patient Safety Institute

0900 – 0945 **KEYNOTE SESSION**
World Health Organization (WHO) Patients for Patient Safety Initiative – Making A Difference Globally

Session Chair: Carolyn Hoffman, Canadian Patient Safety Institute

Susan Sheridan, Chair, Patients for Patient Safety Strand, WHO World Alliance for Patient Safety; Co-Founder, Consumers Advancing Patient Safety

0945 – 1015 **WHO Patients for Patient Safety Initiative in Canada**

Session Chair: Carolyn Hoffman, Canadian Patient Safety Institute

Ryan Sidorchuk, Regional Patient Safety Champion, Patients for Patient Safety Strand, WHO World Alliance for Patient Safety; Patient Safety Officer, Winnipeg Regional Health Authority

1015 – 1030 **Break**

1030 – 1200 **Partnering with Patients: Current Canadian Experiences**

Session Chair: Hélène Sabourin, Canadian Nurses Association

Western Node Speakers:
Christopher Doig, Critical Care Medicine, Foothills Hospital, Calgary Health Region
Elaine Rose, Coordinator, Regional ICU Outreach Program, Calgary Health Region

Ontario Node Speakers:
Wendy McLaughlin, Manager of Utilization and Quality Improvement, Collingwood General and Marine Hospital
Robin Stoer, Perioperative Nurse and Surgical Project Coordinator, Soldiers Memorial Hospital

Quebec Node Speaker:
Anne Lemay, Adjointe au directeur général, et Directrice de la gestion de l'information et de la qualité-performance, CHUM Hôtel-Dieu Hospital

Atlantic Node Speaker:
Paula Creighton, Geriatric Medicine Specialist, Cape Breton District Health Authority

1200 – 1315 **Lunch** Grand Ballroom AB

1315 – 1430 **Adverse Events: Understanding the Impact on the Healthcare Team, the Patient and the Patient's Family** Pavilion Ballroom

Session Chair: Todd Watkins, Canadian Medical Association

Gary Eburne and Cheryle Cook, Family Members

Glen Lowther, Physician, Vancouver Island Health Authority

Debbie Schmidt, Emergency Room Nurse, Vancouver Island Health Authority

1430 – 1445 **Break**

1445 – 1600	**Strategies for Success: Making Disclosure Happen**
	Session Chair: Melanie Rantucci, Canadian Pharmacists Association
	John Banja, Associate Professor of Clinical Ethics, Assistant Director for Health Sciences and Clinical Ethics, Center for Ethics, Emory University
	Beth Kiley, Risk Management Consultant, Capital Health, Nova Scotia
	Jill Taylor, Legal Counsel and Director, Quality Initiatives, Health Quality Council of Alberta
1600 – 1645	**Small Group Discussion**
	Moderators: Susan Sheridan and Ryan Sidorchuk
	Workshop participants will reflect on the discussions of the day and consider opportunities for promoting partnerships for patient safety. Questions to consider include: How can you apply the information presented today to partner with organizations, providers and other patients/family members? What should healthcare organizations, including the workshop partners, do to help enable these relationships?
1645 – 1700	**Closing Remarks**
	Carolyn Hoffman, Canadian Patient Safety Institute

Thursday, October 19, 2006

0800 – 2100	**Registration**	Foyer
1900 – 2100	**Opening Reception and Poster Viewing**	Foyer / Junior Ballroom

Friday, October 20, 2006

0700 – 1730 **Registration and Poster Viewing** — Foyer / Junior Ballroom

0700 – 0800 **Breakfast** — Grand Ballroom (lower level)

0815 – 1000 **Opening Remarks** — Pavilion Ballroom

Trevor Theman, Symposium Co-Chair
Registrar, College of Physicians and Surgeons of Alberta

Patient Safety Announcement

KEYNOTE PRESENTATION

Session Chair: Philip Hassen, Chief Executive Officer, Canadian Patient Safety Institute

Advice for Leaders and Participants Undergoing Change Initiatives
Sir Liam Donaldson, Chair, World Alliance for Patient Safety; Chief Medical Officer, Department of Health, United Kingdom

Sir Liam Donaldson will discuss the purpose of and key programs delivered by the World Alliance for Patient Safety (WAPS),a World Health Organization (WHO) initiative that he helped launch in 2004. The Alliance raises awareness and political commitment to improve the safety of care and facilitates the development of patient safety policy and practice in all WHO Member States. He will also discuss the WAPS in the context of Safety Management Systems.

1000 – 1030 **Break**

1030 – 1230 1

THEME 1: SAFETY MANAGEMENT SYSTEMS (SMS) — Pavilion Ballroom

Session Chair: John Cowell, Chief Executive Officer, Health Quality Council of Alberta

Safety Management Systems In Industry
Dianne Parker, Professor, Department of Psychology, University of Manchester

Dianne Parker will outline the basic components and functions of a formal safety management system, taking the petrochemical industry as an example. She will explain how this approach to managing safety can serve to advance the safety culture of an organization.

Safety Management Systems In Aviation
Rob Lee, International Consultant in Human Factors and Systems Safety

Rob Lee will describe the structure and function of safety management systems used in the aviation industry, and will describe how learnings from both the design and implementation of these may translate to healthcare.

Safety Management Systems In Healthcare
Dorothy Jones, Principal Medical Officer and Director, Office of Safety and Quality in Healthcare, Department of Health, Western Australia

Dorothy Jones will present an overview of the development and results of the Western Australia clinical governance framework, which provides the structure and process to manage patient safety for two million people. She will illustrate how a state health system has aligned clinical leadership, public policy and a safety management system to build better patient outcomes and improved health system accountability.

1230 – 1315 **Lunch** Grand Ballroom

1315 – 1400 **Poster Viewing** Junior Ballroom

1400 – 1600 2 **THEME 2: DESIGNING FOR SAFETY** Pavilion Ballroom

Session Chair: Anthony (Tony) Taylor, Vice President, Quality and Patient Safety, Fraser Health Authority

Problems In Safe Design

Sven Erik Gisvold, Professor, Department of Anaesthesia and Intensive Care, St. Olav University Hospital

Sven Erik Gisvold will talk about the link between hospital design/architecture and function, quality and safety, using as an example a new Scandinavian hospital with a totally decentralized design (one building for each part of the body). This design is extremely expensive to operate and may also represent a threat to patient safety.

The Future of Healthcare Design

Ted C. Braun, Executive Medical Director, South Health Campus, Calgary Health Region

Ted Braun will review the topic of evolution of healthcare design with a focus on current trends and key themes. He will also review the plans for the new South Health Campus site in Calgary. The theme for this campus is "Creating the Future of Healthcare."

How Evidence-Based Design Can Improve Care / Safety While Actually Lowering Costs

Blair Sadler, President Emeritus, Rady Children's Hospital; Senior Fellow, Institute for Heathcare Improvement

Blair Sadler will describe the exploding peer-reviewed research on evidence-based design that shows direct correlations to improved patient and staff quality and safety. He will also discuss the compelling business case for building optimally safe hospitals by understanding the long-term and short-term capital and operating impacts.

1600 – 1730 **Networking Reception** Foyer

Sponsored in part by the Canadian Patient Safety Institute

Saturday, October 21, 2006

0700 – 1615 **Registration and Poster Viewing** Foyer / Junior Ballroom

0700 – 0800 **Breakfast** Grand Ballroom

0800 – 1045 3 **THEME 3: ASPECTS OF CHANGE** Pavilion Ballroom

Session Chair: Lynda Cranston, President and Chief Executive Officer, Provincial Health Services Authority

Change Blindness

Pat Croskerry, Associate Professor, Queen Elizabeth II Health Sciences Centre, Dalhousie University

We cannot change what we cannot see. In this talk, Pat Croskerry will illustrate the phenomenon of change blindness. Some vivid examples will be shown which directly compromise patient care. Such perceptual failures can also be used as a metaphor for change behaviour inertia in patient safety.

Narcissism and the Refusal to Change
John Banja, Associate Professor of Clinical Ethics, Assistant Director for Health Sciences and Clinical Ethics, Center for Ethics, Emory University

It is commonly but incorrectly believed that all narcissism is pathological. In this presentation, John Banja will contrast healthy with unhealthy forms of narcissism, and apply these insights to the personal and professional development of healthcare providers. Further, he will analyze how different constellations of various narcissistic traits can dispose the individual to varying degrees of emotional (and relational) health.

0900 – 0915 **Break**

Legal Barriers to Change
Gerald Robertson, Professor, Faculty of Law, University of Alberta

Gerald Robertson will discuss whether or not there are any legal barriers (real or perceived) to change in the area of patient safety, with particular focus on the issue of disclosure of harm.

The Economic Case for Safety and for Change
Alan Maynard, Professor, Department of Health Services, University of York

A stitch in time may save nine but this requires careful measurement of adverse events and management of their effects. Medical practice is characterized by individual autonomy, significant variations in clinical practice, an absence of outcome measurement and poorly integrated information systems. What is the efficient level of errors, when it is both impossible and too costly to eradicate all mistakes? How can professionals be incentivised to measure and manage better? Alan Maynard will argue that investment decisions in safely in healthcare have to be informed by the cost and benefits of alternative interventions, with careful prioritization of often poorly evaluated "solutions" to complex problems.

1045 – 1100 **Break**

1100 – 1230 4 **THEME 4: *NOT NOW, I'M BUSY:* MEASUREMENT FOR SAFETY** Pavilion Ballroom

Session Chair: John Shepherd, Vice President, Clinical Quality and Safety, Vancouver Coastal Health

Not Now, I'm Busy: Measurement for Safety
Charles Vincent, Smith and Nephew Professor of Clinical Safety Research, Department of Surgery, Oncology, Reproductive Biology and Anaesthetics, Imperial College London

Ross Baker, Professor, Department of Health Policy, Management and Evaluation, University of Toronto

Creating safer healthcare requires measures of clinical and system performance at the microsystem and organizational levels. Ross Baker and Charles Vincent will discuss the types and adequacy of measures that are needed at the local, organizational, and national levels for teams and senior leaders to guide improvements.

1230 – 1315 **Lunch** Grand Ballroom

1315 – 1400 **Poster Viewing** Junior Ballroom

1400 – 1530 5 **THEME 5: HOW PATIENTS AND FAMILIES CAN EFFECT CHANGE** Pavilion Ballroom

Session Chair: Ryan Sidorchuk, Regional Patient Safety Champion, Patients for Patient Safety Strand, WHO World Alliance for Patient Safety; Patient Safety Officer, Winnipeg Regional Health Authority

A Family's Point of View

Margaret Murphy, Patient Advocate and Member, Steering Committee, Patients for Patient Safety Strand, WHO World Alliance for Patient Safety

Margaret Murphy will illustrate the instances and points of contact which failed her son, Kevin, during his patient journey, as well as describe the inadequate responses following his death. She will also speak of how she has engaged positively with the healthcare community in the spirit of the Patients for Patient Safety Strand of the WHO World Alliance for Patient Safety.

An Organization's Point of View

Jim Conway, Senior Fellow, Institute for Healthcare Improvement;
Senior Consultant, Dana-Farber Cancer Institute

Jim Conway will talk about how the Dana-Farber Cancer Institute has responded to the death of a patient, with emphasis on how patients and families are involved in the organization at all levels through advisory councils and patient representatives. He will also discuss the impact of their Center for Patient Safety, created in 2003, a program that brings together clinicians, administrative staff, researchers, patients, and families to promote research, clinical improvement, and education in patient safety.

1530 – 1600 **Advancing Healthcare Safety: Where Do We Go From Here?**

Ward Flemons, Vice President, Quality, Safety and Health Information, Calgary Health Region

Bob Wears, Professor, Department of Emergency Medicine, College of Medicine, University of Florida

In this session, Ward Flemons and Bob Wears will engage Halifax 6 Symposium participants in a discussion of how to advance the culture of safety in Canada and beyond.

1600 – 1615 **Symposium Closing**

Trevor Theman, Symposium Co-Chair