

## Program

All sessions will take place in Confederation Ballrooms II and III unless otherwise noted.

### Thursday, October 11

0700 - 2100	Registration	Foyer
0700 - 0730	Breakfast and Registration	Confederation I
0730 - 0745	<b>Welcome and Opening Remarks</b> Session Chair: Susan Brien, Ottawa	
0745 - 0845	<b>KEYNOTE PRESENTATION</b> <b>Myths, truths and nontraditional insights: patient safety and education</b> Jim Reason, Manchester <i>Session Chair: Phil Hassen, Canadian Patient Safety Institute, Edmonton</i> <i>Training is often seen as the punishment at the end of an investigation into patient harm. Is this actually effective? Are there better ways to make healthcare safer for our patients? In this session, Jim Reason will discuss the roles of education and training in the context of healthcare safety.</i> <i>Participants at both Halifax 7 Pre-symposia will enjoy this dynamic keynote presentation by Jim Reason, the well-renowned pioneer of the organizational framework for the proactive analysis of safety in high technology systems.</i>	
0845 - 0900	Break	Foyer
0900 - 1030	<b>Lessons from High Reliability Organizations (HRO): safety educators in non-healthcare domains</b> Tony Kern, Memphis <i>Session Chair: Susan Brien, Canadian Patient Safety Institute, Ottawa</i> <i>As part of their overall safety initiatives, aviation and other HROs develop and manage educational safety programs. Measuring and learning what works and what does not work is critical to the success of any educational program. In this theme, Tony Kern will review how HROs foster continuous improvement through robust learning strategies, including the development, implementation and evaluation of inter-professional safety education programs. Seminar participants will engage in discussion of the differences and commonalities between healthcare and HROs, with respect to safety learning systems.</i>	
1030 - 1100	Break	Foyer
1100 - 1230	<b>Transforming education strategies with safety and quality tactics: collaboratives, collaborators and collaborative care</b> Session Chair: Carolyn Hoffman, Capital Health, Edmonton <i>In this session, a panel of safety, quality and educational experts will discuss how tactics from safety and quality can be used to transform strategies in safety-focused education.</i> <ul style="list-style-type: none"><li>■ <i>A safety collaborative: Making it work</i> Dean Sandham, Winnipeg</li><li>■ <i>Educating to improve patient safety and reduce liability risks in collaborative care</i> Gord Wallace, Ottawa Sue Swiggum, Ottawa</li></ul>	

■ *Developing a framework of interprofessional patient safety competencies*

Jason Frank, Ottawa  
Susan Brien, Ottawa

1230 – 1330

Lunch

*Confederation I*

1330 – 1430

**Educating providers to communicate with patients:  
the role of health literacy in healthcare safety**

Linda Shohet, Montreal

*Session Chair:* Marlene Smadu, Canadian Nurses Association, Ottawa

*In this session we focus on health literacy, or the “degree to which individuals can obtain, process and understand basic health information and services they need to make appropriate health decisions.”<sup>1</sup> But because healthcare is not just about the individual, so health literacy must be seen to arise “from a convergence of education, health services, and social and cultural fact.”*

*Attendees are invited to bring a sample of patient /family pamphlets or an information sheet from their own organization, which can be evaluated for potential improvement.*

1430 – 1445

Break

*Foyer*

1445 – 1545

**Educating providers to communicate with patients: the role of health literacy in healthcare safety (continued)**

1545 – 1600

**Discussion, summaries & concluding remarks**

1600 – 1630

**KEYNOTE EVENT**

**Launch of the Canadian DVD series, “Delivering Patient Safety”**

1. Health Literacy: A Prescription to End Confusion IOM (2004)

# How Do I Know My Patient Safety Program is Working?

## Program

All sessions will take place in Provinces Ballroom unless otherwise noted.

### Thursday, October 11

0700 - 0730	Breakfast and Registration	<i>Confederation I, Foyer</i>
0730 - 0745	<b>Welcome and Opening Remarks</b> Susan Brien, Ottawa	<i>Confederation II and III</i>
0745 - 0845	<b>KEYNOTE PRESENTATION</b> <i>Session Chair:</i> Phil Hassen, Canadian Patient Safety Institute, Edmonton <b>Can education advance a culture of safety?</b> ■ <i>Myths, truths and nontraditional insights: patient safety and education</i> Jim Reason, Manchester <i>Training is often seen as the punishment at the end of an investigation into patient harm. Is this actually effective? Are there better ways to make healthcare safer for our patients? In this session, Jim Reason will discuss the roles of education and training in the context of healthcare safety.</i> <i>Participants at both Halifax 7 Pre-symposia will enjoy this dynamic keynote presentation by Jim Reason, the well-renowned pioneer of the organizational framework for the proactive analysis of safety in high technology systems.</i>	
0845 - 0900	Break	<i>Foyer</i>
0900 - 1030	<b>Implementation and measurement issues (Part 1)</b> ■ <i>Implementation issues in patient safety</i> Kaveh Shojania, Ottawa <i>There is currently much debate in the patient safety literature on the amount and quality of evidence needed before recommending patient safety interventions for adoption. This debate has largely ignored the problem that, however evidence-based or intuitively plausible an intervention may be, major implementation issues are the rule, not the exception. These physician problems arise from changes in work flow (e.g., medication reconciliation, computerized physician order entry), unexpected interactions between new technologies and existing workflow (e.g., bar-coding), and can befall even the most apparently simple intervention (e.g., removing concentrated potassium from clinical areas). Kaveh Shojania will review some specific examples of implementation issues in patient safety and provide a framework for consideration of these issues.</i> ■ <i>Case study on electronic health records</i> Robyn Tamblyn, Montreal <i>Based on her extensive experience implementing and subsequently evaluating large- and small-scale informatics solutions related to patient safety, Robyn Tamblyn will illustrate the types of problems that can arise during implementation of a complex health system intervention, as well as the difficulties proving that the intervention is effective.</i>	
1030 - 1045	Break	<i>Foyer</i>
1045 - 1200	<b>Implementation and measurement issues (Part 2)</b> ■ <i>Measurement concepts</i> Alan Forster, Ottawa <i>Seminal research studies in patient safety have typically involved intensive chart review methodologies, beginning with screening thousands of charts for potential adverse events and then involving detailed review by physicians to determine if adverse outcomes were caused by medical care and whether or not these outcomes were preventable. At the other end of the spectrum are the voluntary incident reporting systems traditionally used by hospitals. These systems require far fewer resources than systematic chart review, but are well-known to seriously underestimate the number of events and often miss important details of those they do capture.</i>	

Between these two extremes are an increasing number of techniques for measuring adverse events and other safety problems that hospitals may find very promising. Alan Forster will review these specific measurement strategies and discuss their pros and cons, in terms of the types of events likely to be captured (or missed), the quality of the information, and the costs and complexity to implement.

■ **Case study on medication reconciliation**

Ed Etchells, Toronto

As the Director of Patient Safety at Sunnybrook Hospital, Ed Etchells has experience implementing and evaluating the success of a wide range of interventions in terms of their target safety problems and their complexity. He will use examples involving medication reconciliation and smart pumps to illustrate some of the issues involving implementation and evaluation highlighted in the previous presentations.

■ **Panel discussion**

Ed Etchells, Alan Forster, Kaveh Shojania and Robyn Tamblyn will answer questions and encourage participant discussion about implementation and measurement issues.

1200 - 1300

Lunch

*Les Saisons (Level 3), Quebec (Level 4)*

1300 - 1445

**Priority setting and planning**

■ **Framework for selecting candidate patient safety projects**

Kaveh Shojania, Ottawa

The current state of the patient safety literature is such that few interventions have robust evidence to support them. Yet, clearly we have to act in the face of widespread safety problems and cannot wait for perfect evidence for choosing specific solutions. Kaveh Shojania will present a framework that includes the evidence supporting a given intervention, the scope of the problem it addressed, the costs and complexity of implementation, and the possibility of creating new problems. This framework has been used to rate the over 75 different patient safety interventions evaluated in the US Agency for Healthcare Research and Quality's Evidence report, *Making Healthcare Safer*.

■ **Choosing what to do at the local level**

Ed Etchells, Toronto

Ed Etchells will discuss the different factors and their relative weights that have driven decisions by his Patient Safety Service at Sunnybrook Hospital in selecting which specific interventions should be implemented.

■ **Panel discussion**

Ed Etchells, Alan Forster, and Kaveh Shojania will answer questions and encourage participant discussion about implementation and measurement issues.

1445 - 1500

Break

*Foyer*

1500 - 1645

**Critical appraisal - Intervention studies**

■ **How to critically appraise a patient safety study**

Alan Forster, Ottawa

Hospital administrators, project managers, and front line clinicians who want to become involved with patient safety will find themselves faced with the need to know how to review evaluations of the effectiveness of safety interventions. These may be reports of the work done by others in the hospital, which they must assess at meetings, or their own work, which they must present to others at the hospital. In either case, there is a need to understand some of the important concepts in the design and evaluation of even small-scale research projects.

For instance, the most common type of evaluation in the patient safety literature is the before-after study: e.g., these were the number of falls we had last year, and these are number we had this year (after we did A, B, and C). Clearly this type of study is often the best a hospital can do in terms of the resources it has available for evaluation. The key is to know what types of problems can arise from this type of evaluation and in what situation these problems might be particularly serious. This introductory lecture will review these and a handful of other key and recurring concepts in patient safety research.

■ **Small Group Discussion**

Facilitators: Program Faculty

The break out session will involve small group discussions of specific illustrative examples facilitated by the different faculty. One example will involve the evidence for rapid response teams (RRT), where a series of initial before-after studies reported major benefits, but a subsequent randomized controlled trial reported the same benefits in the control hospitals as in the hospitals with RRTs.

1645 - 1700

**Summary and closing remarks**

## Program

All sessions will take place in Confederation Ballrooms II and III unless otherwise noted.



**Moderator: Adrian Harewood**, Host, *All In A Day*, CBC Radio, Ottawa

### Thursday, October 11

0700 – 2100

Registration

Foyer

1800 – 1900

#### “Swiss Cheese Lecture”

(Optional)

Kaveh Shojania, Ottawa

*The initial years of the healthcare safety movement have understandably focused on highlighting the scope of the problem and generating enthusiasm for change. But there have already been many examples of initiatives producing less than hoped-for results. Although achieving small to modest improvements is a common occurrence in any area of research, not being able to resolve all the safety problems can contribute to loss of enthusiasm. In this lecture, Kaveh Shojania will outline some of the tensions between maintaining the momentum of the healthcare safety movement and creating the foundation for a rigorous biomedical endeavour. In so doing, he will review important healthcare safety terms and concepts – a primer for first-time conference attendees and a refresher for alumni.*

1900 – 2100

Opening Reception

Foyer

### Friday, October 12

0700 – 1645

Registration

Foyer

0700 – 0800

Breakfast

Level 4

0800 – 1730

Poster Viewing

Provinces

0800 – 0840

#### Opening Remarks

The Honourable Tony Clement, Minister of Health and the Minister for the Federal Economic Development Initiative for Northern Ontario  
Sharon Caughey, Ottawa, Symposium Co-Chair  
Philip Hassen, Edmonton, Canadian Patient Safety Institute

0840 – 0950

#### KEYNOTE PRESENTATION

Speaker introduction: James Reason, Manchester

#### Can healthcare ever be safe?

Donald Berwick, Boston

*Safety of patients and staff is a leading concern for any healthcare system engaging improvement as a strategy. The barriers to success are high, but they can be overcome with sufficient constancy of purpose on the part of senior executives and clinical leaders. Donald Berwick will explore strategies for leadership, and new roles for both executives and boards.*

*The Royal College of Physicians and Surgeons of Canada, Region 3 Advisory Committee, has provided a continuing medical education grant in support of our meeting.*

*Sir Donald Berwick is the designated speaker of the Royal College of Physicians and Surgeons of Canada, Region 3 Advisory Committee.*

0950 – 1020 Break and Poster Viewing *Foyer, Provinces*

1020 – 1140 **THEME 1: CONTROVERSIES IN STAFFING**

**How qualified?**

Jack Needleman, Los Angeles

*Research reports have described that patients treated by 'less qualified' staff have poorer outcomes or are more likely to experience complications, with the 'obvious' solution to these problems being the use of more qualified personnel. Questioning if this is the correct inference, Jack Needleman explores the meaning and interpretation of such research by examining four staffing issues: the mix of LPNs and RNs, the impact of employing more baccalaureate prepared nurses, the use of nurse anesthetists, and the use of pharmacy assistants.*

**Is a tired worker better than no worker?**

Drew Dawson, Adelaide

*Insufficient attention has been paid to the effects of sleep deprivation and sleep debt on patient safety. The impact of sleep deprivation on human performance is comparable to that of alcohol intoxication, yet healthcare workers continue to work traditional, taxing schedules. One of the reasons cited for this is the shortage of workers. Drew Dawson considers if a tired worker is better than none and describes the Queensland Health experience of development of a practical fatigue risk management system in healthcare.*

1140 – 1215 Lunch *Level 4*

1215 – 1300 Networking and Poster Viewing *Provinces*

1300 – 1500 **THEME 2: ORGANIZATIONAL CONTROVERSIES**

**Behaviour change versus culture change?**

David DeJoy, Atlanta

*In this presentation, David DeJoy compares and contrasts two prominent approaches to managing workplace safety: behaviour versus culture-based change. The former is an extension of behaviour modification while the latter comes largely from management and organizational theory. While often viewed as contradictory, these two approaches can complement each other and their respective strengths can be merged into a more balanced and comprehensive programming model. David DeJoy will discuss this proposed integrative model in terms of current safety challenges facing the healthcare sector.*

**Does an organization need a catastrophe to change?**

Gerry Marr, Tayside

*Not all change need be prompted by bad news. Gerry Marr will demonstrate, from a Chief Executive's point of view, the daily importance of making patient safety a strategic priority. He will describe how safety can be cascaded from the board room to the bedside and will use examples of evidence-based interventions and reliable measures to show dramatic improvement over time in the reduction of harm to patients requiring hospital treatment.*

**Does accreditation make a hospital safe(r)?**

Ellie Scrivens, Trent

*While accreditation has become increasingly popular throughout the world as a mechanism for promoting quality in healthcare, some question the ability of accreditation to contribute to safer healthcare. Ellie Scrivens examines these questions and discusses how far they are justified and if the main aims and purposes of accreditation have been distorted by the desire to reform healthcare systems. She also examines if accreditation should return to its initial purpose of checklists of processes and procedures known to promote safety and which create a safe environment for good clinical practice.*

1500 – 1530 Break and Poster Viewing *Foyer, Provinces*

1530 – 1630 **KEYNOTE PRESENTATIONS: NATIONAL CONTROVERSIES**

**Can healthcare ever be as safe as aviation? Reflections from the National Patient Safety Agency in England and Wales**

Naren Patel, Dunkeld; Martin Fletcher, London

*What has the National Patient Safety Agency achieved? Has national reporting helped make healthcare safer? Are there lessons for others from the experiences in*

England and Wales? In this presentation Naren Patel and Martin Fletcher will provide an overview and analysis of the work of the National Patient Safety Agency, highlight key challenges, and outline how the national patient safety agenda is being taken forward.

1630 – 1700

### Rapporteurs of Day 1

Alan Forster, Ottawa; Bob Wears, Jacksonville

Our rapporteurs will summarize the key learnings and themes that emerged over the day, and actively collect participant input on “What I’ve heard that I’m going to do differently over the next year.”

1700 – 1800

Networking Reception

Sponsored by the Canadian Patient Safety Institute

Foyer

## Saturday, October 13

0700 – 1645

Registration

Foyer

0700 – 0800

Breakfast

Level 4

0800 – 1300

Poster Viewing

Provinces

0800 – 1000

### THEME 3: IGNORING EVIDENCE

#### Pay now or pay later: designing for safety

Kirk Hamilton, College Station

Evidence-based design can be considered to be an analog of evidence-based medicine. Kirk Hamilton will provide an introduction to this topic and explore the role and influence of the environment and facility design on safety and clinical outcomes. He will also provide participants with resources to further explore the topic and relate it to their own circumstances.

#### Superbugs: why bother?

Marc Bonten, Utrecht

It is widely assumed that bacteria resistant to multiple classes of antibiotics – or ‘superbugs’ – have a detrimental effect on outcome, especially in hospitalized patients. As a result, much effort worldwide is put into prevention of the spread of resistant bacteria in hospitals. Marc Bonten will describe the difficulty in determining the contribution of infections caused by such bacteria on the ultimate result of hospital treatment and in balancing the costs and benefits of prevention measures.

#### What is evidence-based practice and when is it an oxymoron?

Hugh McKenna, Londonderry

As a term, ‘evidence-based practice’ is becoming as trite as ‘quality assurance’ or ‘patient centred care’. Hugh McKenna will attempt to re-humanise evidence-based practice and uncover its true potential. He will also explore what clinicians can do when there is no evidence to underpin their practice or when the existing evidence is available but is unsuitable for individual patients.

1000 – 1020

Break and Poster Viewing

Foyer, Provinces

1020 – 1140

### THEME 4: ‘SELLING’ SAFETY CONCEPTS

#### Recruiting a hundred thousand eyes and selling what they see

Paul Hodgkin, Sheffield

Learning about what patients and their families see and experience can help healthcare providers, hospitals and regions provide better and safer care. In this presentation, Paul Hodgkin describes ‘Patient Opinion’, a not-for-profit, advertising-free website that collects web-based comments about the safety and aesthetics of care, converts these to patient-generated ratings, and then sells them to hospitals with the aim of improving services.

#### An ‘ad man’ speaks

Chuck Husak, Bethesda

Many different organizations have attempted to ‘market safety’, to varying degrees of effectiveness. Chuck Husak will provide examples of these and then identify some of the concepts that must be considered before attempting such a campaign. He will also describe different media options and how identifying one’s audience, and one’s message, should influence media decisions.

1140 – 1215  
1215 – 1300  
1300 – 1500

Lunch  
Networking and Poster Viewing

Level 4  
Provinces

## THEME 5: WHEN A HEALTHCARE WORKER IS THE PATIENT

### **The doctor is in... bed two**

Philip Hébert, Toronto

*What happens when the doctor is a patient? Does he or she receive care that is better or worse than that received by non-medically qualified patients? What might this tell us about things going wrong and about overall patient safety in healthcare? In this talk, Philip Hébert will reflect on these questions from the perspective of the doctor-as-patient.*

### **Primum non tacere, or why don't we speak up?**

John Banja, Atlanta

*Many health professionals are reluctant to question certain organizational or professional behaviors, practice patterns, and policies. That reluctance is attributed to fears of reprisal or professional embarrassment, with the unfortunate result that numerous suboptimal practices which threaten patient care or safety go unremediated. John Banja will review organizational, cultural and psychological explanations for these inhibitions and will give suggestions for healthcare providers and administrators who wish to cultivate a professional environment of accountability, respect, justice, and patient-centeredness.*

### **Can we learn from our own experiences as patients?**

Robert Klitzman, New York

*Many doctors feel that because they are powerful healers, they will never become ill themselves. When they do, the experience of becoming a patient initiates a profound shift of awareness – not only in their sense of their selves, but in the way they view their patients and the doctor-patient relationship. Robert Klitzman will describe these often dramatic transformations and relate how the experiences of doctors and other healthcare providers who become patients can serve as unique resources for a more humane future for healthcare.*

1500 – 1530

### **Rapporteurs of Day 2**

Alan Forster, Ottawa; Bob Wears, Jacksonville

*Once again, our rapporteurs will summarize salient issues discussed during the day and solicit audience participation in a discussion of what we should do individually and collectively in the next week, and over the next year, to accelerate safety in healthcare.*

1530 – 1545

### **Symposium Closing**

#### **Presentation of Award for Best Poster**

Sharon Caughey, Ottawa, Symposium Co-Chair