

HALIFAX 9 / October 22 to 24, 2009
Le Centre Sheraton Montréal, Montréal, Quebec

www.buksa.com/halifax

SYMPOSIUM PROGRAM

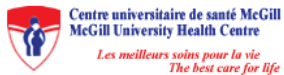
A provocative forum for leaders to advance safety,
cultivate relationships and shape the future of healthcare

Human Performance and Healthcare Safety

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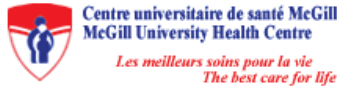


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HALIFAX SYMPOSIA

Letter of Welcome

On behalf of the host organizations, welcome to Montréal and to *Halifax 9: The Ninth Canadian Healthcare Safety Symposium!*


While much of the healthcare system requires redesign to advance healthcare safety, human performance remains a vitally important factor in this most human of all high hazard endeavours. How workers perceive, think, and perform can make the difference between death and life, suffering and successful treatment, or illness and wellness.

Halifax 9 will explore human performance as it relates to healthcare safety by looking at the factors of individual variability and performance, seeing/doing/teaching, technological advances, team and cultural communication, competencies, and how we tell stories. By delving into these factors and their interactions with the systems in which we work, we hope to gain a greater understanding of the relationships and how we can both adjust for and improve human performance to advance healthcare safety.

We hope that Halifax 9 will provide you with a unique opportunity to network with our outstanding speakers and with other delegates.

As the venue for Halifax 9, Montréal is one of Canada's most exciting cities. You will find art, museums, restaurants, shopping, and a rich history within close proximity. Please take time to enjoy!

We look forward to meeting with you. Again, welcome to Montréal!

The badge is rectangular with a white background. At the top, it says 'HALIFAX SERIES' in blue and 'MONTRÉAL 2009' in blue. Below this is a graphic of a city skyline with a green globe icon. On the left side, there is a green vertical banner with the text 'Le symposium sur la sécurité des soins de santé au Canada'. On the right side, there is a green vertical banner with the text 'The Canadian Healthcare Safety Symposium'. At the bottom, it says 'Les entretiens d'Halifax' in blue.

Micheline Ste-Marie
Micheline Ste-Marie
Co-Chair, Halifax 9 Organizing Committee
Associate Director of Professional Services
Montreal Children's Hospital

Jan M. Davies
Jan Davies
Co-Chair, Halifax 9 Organizing Committee
Professor of Anesthesia, Faculty of Medicine
University of Calgary



The Halifax Symposia

The Halifax Series has evolved into Canada's flagship event in healthcare safety. Participants from previous meetings have consistently remarked about the meeting being innovative, cutting edge, and intellectually challenging.

The meeting is different by design. In developing the early programs, the founders of the Halifax Series sought inspiration within healthcare and in other industries around the world for different ideas, knowledge, skills and attitudes which would present opportunities for the improvement of healthcare safety in Canada. The Halifax Series Organizing Committee has diligently continued this approach.

Halifax Symposium attendees can expect:

- A challenging learning opportunity, designed for senior leaders and clinicians in healthcare
- A program that allows every registrant to participate in every session, and that contains no profession-specific sessions
- Themes that are academic in focus, and that examine issues from a variety of perspectives
- Speakers who are selected for their expertise, and not because they represent a discipline, a profession, or an organization
- Sessions that explore the safety experiences of other industries
- A conference that has limited capacity, so as to preserve the intimacy of the interactions among delegates and speakers

The Halifax Series was founded in 2000 by Dr. Pat Croskerry of Dalhousie University. In 2004 a consortium of Alberta organizations agreed to assume responsibility for the event: Calgary Health Region, Capital Health, the College of Physicians and Surgeons of Alberta, and the Health Quality of Council of Alberta. After organizing the next three meetings, the Alberta consortium transferred stewardship to the Canadian Patient Safety Institute. The organization of the meeting is governed by the principles established by the founder and the Alberta consortium, and the Canadian Patient Safety Institute.

Program Accreditation

CCHSE MAINTENANCE OF CERTIFICATION

Attendance at this program entitles certified Canadian College of Health Service Executives members (CHE / Fellow) to **6.5 Category II credits** toward their maintenance of certification requirement.



PHYSICIAN MAINTENANCE OF CERTIFICATION

This event is approved for up to **22 credits** by the Centre for Continuing Health Professional Education (CCHPE). The Centre for CCHPE, Faculty of Medicine, McGill University is fully accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS) and through the CACMS is accredited to award AMA PRA category 1 credit.

This event is an Accredited Group Learning Activity as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.

Through a reciprocal agreement, The Centre for CCHPE, Faculty of Medicine, McGill University designates this activity for AMA Physicians Recognition Award, Category 1 credit up to the maximum number of credit hours noted above.

Each physician should claim only those hours of credit that he/she actually spent at the educational activity.

Halifax Series Secretariat

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Schedule-at-a-Glance

Thursday, October 22

- 0730 - 1700 **PRE-CONFERENCE EVENT 1 (PAGE 10)**
From Communication to Comprehension: Focus on Health Literacy
Sal de bal est
- 0730 - 1700 **PRE-CONFERENCE EVENT 2 (PAGE 14)**
Designing with Safety in Mind
Salle de bal centre and ouest
- 1800 - 1930 **IMPLEMENTING PATIENT SAFETY RESEARCH RESULTS:**
CPSI funded research presentations
Salle de bal centre and ouest
- 1930 - 2100 **HALIFAX 9 – OPENING RECEPTION AND REGISTRATION**
Foyer Salle de bal

Friday, October 23

All sessions in Salle de bal centre and ouest unless otherwise noted

- 0700 - 0745 **Breakfast, Registration and Poster Viewing**
Foyer Salle de bal
- 0800 - 0830 **OPENING**
- 0830 - 0845 **THEATRICAL PERFORMANCE: Théâtre à la carte**
- 0845 - 1000 **KEYNOTE – Safety, deviation and human performance – René Amalberti**
- 1000 - 1030 **Break and Poster Viewing**
Foyer Salle de bal, Salle de bal est
- 1030 - 1145 **THEME 1 – SQUARE PEGS / ROUND HOLES**
Individual variability, error proneness and human performance
– *John W. Senders*
Personality and performance in the healthcare industry – *Robert Hogan*
- 1145 - 1230 **Lunch**
Salons 4 and 5, 6 and 7, Drummond
- 1230 - 1300 **Poster Viewing**
Salle de bal est
- 1300 - 1500 **THEME 2 – SEE 1, DO 1, TEACH 1...**
Understanding what is really going on – *John Wilson*
In pursuit of expertise – *Bruce C. Dunphy*
A critical appraisal of medical simulation in 2009 – *Kevin LaChapelle*

- 1500 - 1520 **Break and Poster Viewing**
Foyer Salle de bal, Salle de bal est
- 1520 - 1715 **THEME 3 – DID YOU SEE THE LATEST?**
“Mayday! Mayday! Mayday!” – *Bert Ruitenberg*
“Start spreading the news!” – *Nathalie de Marcellis-Warin*
Voice loops and overhearing – *David D. Woods*
- 1720 - 1900 **RECEPTION and Poster Viewing**
Foyer Salle de bal, Salle de bal est

Saturday, October 24

- 0700 - 0745 **Breakfast and Poster Viewing**
Foyer Salle de bal, Salons 6 and 7, Drummond
- 0800 - 0815 **THEATRICAL PERFORMANCE – Théâtre à la carte**
- 0815 - 1015 **THEME 4 – “WHAT DID YOU SAY? WHAT DO YOU MEAN?”**
Communicating in teams – *Rhona Flin*
The sounds of silence – *Lorelei Lingard*
Translation or interpretation? – *Pascal Singy*
- 1015 - 1045 **Break and Poster Viewing**
Foyer Salle de bal, Salle de bal est
- 1045 - 1200 **THEME 5 – BUT SURELY I’M COMPETENT...**
Individual competence – *Cliff Hughes*
Creating teamwork when the lives of others depend on it – *Eduardo Salas*
- 1200 - 1245 **Lunch**
Salons 4 and 5, 6 and 7, Drummond
- 1245 - 1300 **Poster Viewing**
Salle de bal est
- 1300 - 1315 **The “Golden Safety Pin” Award**
- 1315 - 1430 **Leading for resilience – Kathleen M. Sutcliffe**
Building system competence – *Stephen Duckett*
- 1430 - 1530 **THEME 6 – TELL ME A STORY – Vincent Lam**
- 1530 **CLOSING**

CORE PROGRAM

Human Performance and Healthcare Safety

Learning Objectives

At the end of this Symposium, participants will be able to:

- Summarize how individual variability and personality can impact human performance and its relation to healthcare safety.
- Review training and education strategies and their effect on job performance, by reflecting on traditional definitions of expertise and Cognitive Work Analysis, and considering future uses for medical simulation as an education tool.
- Discuss how new technologies – from other industries – can both aid and impede communication in the healthcare workplace.
- Distinguish communication measures in team environments resulting from individual styles, the dimensions of silence, and cultural factors.
- Evaluate competence and its influence at an individual, team, administrative and system level.
- Identify story-telling as a tool to better communicate with patients and with the public.



Program

All sessions will take place in Salle de bal centre and ouest unless otherwise noted.

Symposium moderators:

Steven Lewis, Saskatoon, Saskatchewan

Micheline Ste-Marie, Montréal, Quebec

Thursday, October 22, 2009

1800 - 1930 **IMPLEMENTING PATIENT SAFETY RESEARCH RESULTS: CPSI funded research presentations**

This evening event is open to all registrants at no charge. Come to this informative and interactive session, where you will hear the results of several research projects funded by the CPSI and commentary on their application. The dialogue will include a brief description of each project with an emphasis on “so what?” and “now what?” These projects offer evidence of leading practices and assessment of implementation challenges.

1930 - 2100 **OPENING RECEPTION**

Foyer Salle de bal

Friday, October 23, 2009

0700 - 0745 **Breakfast, Registration and Poster viewing**

Foyer Salle de bal, Salons 6 and 7, Drummond

0800 - 0830 **OPENING**

Micheline Ste-Marie, Co-chair,

Symposium Organizing Committee, Montréal, Quebec

The Honourable Yves Bolduc,

Ministère de la Santé et des Services sociaux,

Gouvernement du Québec

Phil Hassen, Chief Executive Officer,

Canadian Patient Safety Institute, Edmonton, Alberta

0830 - 0845 **THEATRICAL PERFORMANCE:**

Théâtre à la carte

0845 - 1000

KEYNOTE PRESENTATION

Safety, deviation and human performance

René Amalberti, Paris, France

Safety rules and recommendations continue growing rapidly, as if constraining human behaviour were the unique avenue for reaching ultimate safety. Safety rules and standards, especially when evidence based, are of course an essential foundation of a safe system. However the multiplication of safety rules and procedures, and the inclusion of more and more process-oriented rules, can potentially have counterproductive effects. The main problem with such a multiplication of rules is not so much their potential intrinsic value but compliance with them. We know some barriers and facilitators that hinder and help healthcare workers from following guidelines. When introducing a new policy or procedure, therefore, it is important to start by identifying potential barriers and having realistic expectations about compliance. René Amalberti describes the six usual flaws observed in designing medical rules; he proposes a simple strategy to be used in the design phase to reduce the risk of future non-compliance.

1000 - 1030

Break and Poster Viewing

Foyer Salle de bal, Salle de bal est

1030 - 1145

THEME 1

SQUARE PEGS / ROUND HOLES

Individual variability, error proneness and human performance

John W. Senders, Toronto, Ontario

John Senders will discuss the obvious differences between people in their ability to *perform* a task and the equally obvious differences between a person's ability to *perform* at different times. A failure to perform perfectly is usually attributed to insufficient ability to meet the demand. Error, on the other hand, names a failure to perform when the capacity meets the demand but performance is defective. He will also discuss the very important question: are some people "error prone", i.e., more likely than others to err?

Personality and performance in the healthcare industry

Robert Hogan, Jacksonville, Florida

Many people think IQ is the most important determinant of job performance, but personality matters more, and in the healthcare industry it matters in very specific ways. For example, good healthcare providers at any level must project a sense of caring, which can be perceived as being more important than the actual quality of the care delivered. Robert Hogan will describe how coldness and indifference are the principal stimuli for dissatisfaction with care, complaints to hospitals and licensing authorities, and to medical malpractice suits.

1145 - 1230

Lunch

Salons 4 and 5, 6 and 7, Drummond

1230 - 1300

Poster Viewing

Salle de bal est

1300 - 1500

THEME 2

SEE 1, DO 1, TEACH 1...

Understanding what is really going on: Approaches to cognitive work analysis

John Wilson, Nottingham, England

Before we can begin to understand the problems and risks in current work systems, or to develop new technical and organizational designs, we must understand what it is that the people concerned actually do. This means carrying out various levels of work analysis, and since the setting of work and other contextual factors are so crucial, has usually meant substantial field study. Because "classical" task analysis was seen by some (wrongly) as primarily concerned with physical and not cognitive work, there have of late been substantial developments in what is known as cognitive work analysis. John Wilson will discuss various forms of (cognitive) work analysis, and their relevance to different types of work and work systems. He will draw examples from current work in the railway systems.

In pursuit of expertise

Bruce C. Dunphy, Brisbane, Australia

Bruce Dunphy starts his presentation with a discussion of how expertise is defined. He will analyze, compare and contrast models for the development of expertise and will outline implications of

these models for healthcare education and practice, drawing on examples from practice. He will also explore related areas that may have an impact on the incidence of errors and the quality of patient outcomes, including complications.

A critical appraisal of medical simulation in 2009

Kevin LaChapelle, Montréal, Quebec

Medical Simulation as an educational tool is here to stay. Beyond the initial excitement, significant challenges face healthcare providers and educators in the widespread integration and use of this 'new' approach to teaching and learning. Kevin LaChapelle will outline some of the challenges in Medical Simulation, including the lack of time and a shortage of dedicated and trained faculty, as well as the paucity of outcome data.

1500 - 1520

Break and Poster Viewing

Foyer Salle de bal, Salle de bal est

1520 - 1715

THEME 3

DID YOU SEE THE LATEST?

“Mayday! Mayday! Mayday!” or
“✈️🚑🚒🚓🚔🚕🚚🚛🚝🚞🚟🚠🚡🚢🚣🚤🚥🚦🚧🚨🚩🚪🚫🚬🚭🚮🚯🚰🚱🚲🚳🚴🚵🚶🚷🚸🚹🚺🚻🚼🚽🚾🚿🛖🛗🛘🛙🛚🛛🛜🛝🛞🛟🛠🛡🛢🛣🛤🛥🛦🛧🛨🛩🛪🛫🛬🛭🛮🛯🛰🛱🛲🛳🛴🛵🛶🛷🛸🛹🛺🛻🛼🛽🛾🛿🚲🚳🚴🚵🚶🚷🚸🚹🚺🚻🚼🚽🚾🚿🛖🛗🛘🛙🛚🛛🛜🛝🛞🛟🛠🛡🛢🛣🛤🛥🛦🛧🛨🛩🛪🛫🛬🛭🛮🛯🛰🛱🛲🛳🛴🛵🛶🛷🛸🛹🛺🛻🛼🛽🛾🛿”

Air Traffic Control, the need for unambiguous communication, and the transition from voice to data link communication

Bert Ruitenbergh, Amsterdam, Netherlands

Bert Ruitenbergh will use an accident case study to illustrate the relevance of clear communications in aviation and air traffic control. He will describe systemic aspects of air traffic control safety. He will also present the implications – both positive and negative – of technological advances, such as data link communication.

“Start spreading the news!” RISQ+H* in Quebec as a model for everywhere else

Nathalie de Marcellis-Warin, Montréal, Quebec

The network for risk management, patient safety and quality in hospitals experience sharing and dissemination (RISQ+H) was created in Quebec. The purpose of RISQ+H was to support the transfer of risk management and patient safety research into practice, to provide a forum where practitioners could share their experiences, risk management tools, and successful outcomes, and to integrate

healthcare practitioners into multidisciplinary research projects. A Web site (www.risqh.org) was set up as the principal vehicle to disseminate information about healthcare safety. In addition to networking and members' online interactions, workshop and experience-sharing sessions with other high-hazard industries are planned. Each activity addresses a specific theme, allowing research and practice to be paired. Nathalie de Marcellis-Warin will discuss the goals of the network, the description of the internet-based communication system and first results.

* Network for awareness and experience sharing in risk management, patient safety and quality of care

Voice loops and overhearing: From NASA to the ICU

David D. Woods, Columbus, Ohio

What do the space shuttle mission control and healthcare have in common? In this presentation, David Woods describes the need for both domains to have personnel widely distributed yet able to respond quickly in a coordinated way. In NASA space shuttle mission control, voice loops facilitate multi-channel, direct communication among personnel who are physically separate yet who can overhear potentially relevant conversations. David Woods details the application of voice loops to various areas in healthcare, including the ICU, with benefits for primary decision makers, nurse supervisors, peer-to-peer hand-off updates, and specialist consultations.

1720 - 1900

RECEPTION and Poster Viewing

Foyer Salle de bal, Salle de bal est

Saturday, October 24, 2009

0700 - 0745

Breakfast and Poster Viewing

Foyer Salle de bal, Salons 6 and 7, Drummond

0800 - 0815

THEATRICAL PERFORMANCE: *Théâtre à la carte*

0815 - 1015

THEME 4

“WHAT DID YOU SAY? WHAT DO YOU MEAN?”

Communicating in teams

Rhona Flin, Old Aberdeen, Scotland

Communication failures within and across healthcare teams are a major contributor to adverse events for patients. Demanding task

conditions, coupled with status effects, role ambiguity, professional rivalries and a lack of group cohesion result in a challenging work environment that requires healthcare professionals to have high-level communication skills. Drawing from recent research into the role of non-technical skills in maintaining safe and efficient clinical practice, Rhona Flin will examine behaviours relating to effective communication within and between teams.

The sounds of silence: Complexities in the evaluation of team communication

Lorelei Lingard, Toronto, Ontario

Team communication is central to safe healthcare, and the objective evaluation of communication is necessary to support improvement efforts. However, measures of team communication tend to focus on 'presence' (communications that can be directly seen/heard), and are not well equipped to deal with 'absence' (communicative silences). Silence abounds in healthcare teams and a comprehensive accounting of team communication must grapple with the meanings of silence, including both its functional and problematic dimensions. Drawing on data from a four year, multi-institutional study of Operating Room team communication, Lorelai Lingard will describe recurrent patterns of silence in this team environment, consider the actions and relations that these silences embody, and discuss their implications for sophisticated evaluation of the communicative behaviour of healthcare teams.

Translation or interpretation?

Pascal Singy, Lausanne, Switzerland

In most western countries, the presence of a professional translator during doctor/migrant patient appointments can restore somewhat of a balance between the local population and the immigrant population. However, if resorting to a translating third party allows the migrant patient to be heard, it still creates problems. Indeed, the job description of this third party may be controversial: must we consider this person to be a living dictionary doing a word for word translation or should we see him or her as a genuine actor who has an influence on the unfolding of the consultation?

1015 - 1045

Break and Poster Viewing

Foyer Salle de bal, Salle de bal est

1045 - 1200

THEME 5

BUT SURELY I'M COMPETENT...

Individual competence

Cliff Hughes, Sydney, Australia

In this presentation, Cliff Hughes first examines the traditional definition(s) and measurement of a worker's competence in healthcare, using his own example as a senior cardiac surgeon. He then provides, through a first-person story of one of his many experiences with the Australian railways, an illustration of how individual job-related competence is only part of what is now required in healthcare. Specifically, he describes the competent individual, who, when engaged in work, as needing an 'environmental' awareness, aptly captured by the phrase 'listen to the rhythm'.

Creating teamwork when the lives of others depend on it: Competencies that matter...

Eduardo Salas, Orlando, Florida

Eduardo Salas will briefly highlight the evidence-based competencies needed to transform a team of experts into an expert team. He will outline the specific knowledge, skills and attitudes that are essential to function as a high reliability team and how team training can help.

1200 - 1245

Lunch

Salons 4 et 5, 6 et 7, Drummond

1245 - 1300

Poster Viewing

Salle de bal est

1300 - 1315

The "Golden Safety Pin" Award

Presenting Judge: Colin Neale, Montréal

Screening of selected safety videos entered in the "Safety Video Contest", with presentation of the prize to the winning video.

1315 - 1430

Leading for resilience

Kathleen M. Sutcliffe, Ann Arbor, Michigan

Leadership in complex organizations is difficult in part because leaders have been exhorted to anticipate, plan, envision, forecast, and strategize. Neglected in all the talk about foresight are the

processes of intelligent reaction and improvisation, which reflect a commitment to resilience. In this session, Kathleen Sutcliffe will consider practices that leaders can use to enable their employees and organizations both to avoid unexpected surprises and to cope and bounce back from them once they become manifest.

**Building system competence:
The Queensland Health experience**

Stephen Duckett, Edmonton, Alberta

In the wake of a significant safety scandal in 2005, there was a shake up of senior leadership (Ministerial and Departmental) in this large (approximately 60,000 employees) public provider. Stephen Duckett will discuss the revised system of clinical governance which was implemented, based on three process values: participation, transparency and accountability. Several organisational and system initiatives were undertaken, including new approaches using routine data sets to track clinical outcomes and institutional responses to identified variation from the state average. In addition, a new 'Clinical Practice Improvement Payment', a form of Pay for Performance, was initiated, to encourage adherence to agreed process measures of good care.

1430 - 1530

THEME 6

TELL ME A STORY

Vincent Lam, Toronto, Ontario

The provision of healthcare is all about story-telling. How can we better understand patients' stories by exploring the process of story-telling? Vincent Lam discusses the link between narrative and science, which come together in the art of medicine.

1530

CLOSING

Mark your calendars!



The Canadian Healthcare Safety Symposium 10
October 21 - 23, 2010
Halifax, Nova Scotia

Organizing Committee

Co-chair: Jan Davies MSc MD FRCPC

Professor, Department of Anesthesia, Faculty of Medicine;
Adjunct Professor of Psychology, Faculty of Social Sciences,
University of Calgary

Co-chair: Micheline Ste-Marie MD

Associate Director of Professional Services, Montréal Children's
Hospital, McGill University Health Centre

Ross Baker PhD

Professor, Health Policy, Management and Evaluation, Faculty of
Medicine, University of Toronto

Doug Cochrane MD FRCSC FAAP

Chair, British Columbia Patient Safety Task Force, Provincial
Health Services Authority

Pat Croskerry MD PhD

Professor, Department of Emergency Medicine, Dalhousie
University

Mark Daly RRT MA(Ed)

Patient Safety Coordinator, McGill University Health Centre

Philip Hassen MPH FCCHSE

Chief Executive Officer, Canadian Patient Safety Institute

Rob Robson MDCM FRCPC

Chief Patient Safety Officer, Winnipeg Regional Health Authority

Laurel Taylor PhD

Director of Operations, Canadian Patient Safety Institute

Laurie Thompson RN MN

Executive Director, Manitoba Institute for Patient Safety

Jewel Buksa MBA

President, BUKSA Strategic Conference Services

Faculty

Visit the Symposium website for detailed biographies of our faculty.

René Amalberti MD PhD

HAS (Haute Autorité de Santé), Saint-Denis La Plaine Cedex, France

Nathalie De Marcellis-Warin DEA PhD

Associate Professor, Department of Mathematical and Industrial Engineering, École Polytechnique Montréal, Montréal, Quebec

Stephen Duckett PhD DSc FCHSE FASSA

President and Chief Executive Officer, Alberta Health Services, Edmonton, Alberta

Bruce Dunphy MBChB MD MEd FRCOG PhD CREI FRANZCOG

Monash IVF Medical Director, Sunnybank, Queensland, Australia

Rhona Flin BSc PhD FBPsS FRSE

Professor, School of Psychology, University of Aberdeen, Old Aberdeen, Scotland

Robert Hogan PhD

President, Hogan Assessment Systems, Tulsa, Oklahoma

Clifford Hughes

Chief Executive Officer, Clinical Excellence Commission, Sydney, Australia

Kevin Lachapelle MD FRCSC FACS

Associate Professor of Surgery, Faculty of Medicine, McGill University, Montréal, Quebec

Vincent Lam MD

Emergency Physician, Toronto East General Hospital; Author; Toronto, Ontario

Steven Lewis

President, Access Consulting, Saskatoon, Saskatchewan

Lorelei Lingard PhD

Professor, Department of Medicine; Director, Centre for Education Research and Innovation Schulich School of Medicine and Dentistry University of Western Ontario

Bert Ruitenber

Human Factor Specialist, International Federation of Air Traffic Controllers' Associations, Amsterdam, The Netherlands

Eduardo Salas PhD MS BA

Trustee Chair and Professor of Psychology, University of Central Florida; Program Director for Human Systems Integration Research Department at the Institute for Simulation & Training; Orlando, Florida

John W. Senders PhD

Consulting Scientist; Professor Emeritus, University of Toronto, Toronto, Ontario

Pascal Singy PhD

Linguistics Professor and Research Center Director, Lausanne University and University Hospital Lausanne, Lausanne, Switzerland

Micheline Ste-Marie MD

Associate Director of Professional Services, Montréal Children's Hospital, McGill University Health Centre, Montréal, Quebec

Kathleen Sutcliffe PhD

Associate Dean, Faculty of Development and Research, University of Michigan Ross School of Business, Ann Arbor, Michigan

John Wilson BTech MSc PhD DSc

Director of the Institute of Occupational Ergonomics and Professor of Human Factors, School of Mechanical, Materials and Manufacturing Engineering, University of Nottingham, Nottingham, United Kingdom

David D. Woods PhD

Professor, Institute for Ergonomics, Ohio State University, Columbus, Ohio

Halifax 9 Pre-Conference Event

Thursday, October 22, 2009

Pre-Conference 1 will not be webcast or recorded.

PRE-CONFERENCE 1

From Communication to Comprehension: Focus on Health Literacy

Program Overview

Problems with communication between patients and healthcare providers have been implicated in many adverse events, in part because of co-existing problems with comprehension. These difficulties with communication and comprehension are sometimes related to low levels of health literacy, which includes the ability to read and understand factual and numerical health-related information.

Low levels of health literacy affect all sectors of the population and have many implications for patient safety. Without adequate health literacy skills, patients may not understand or may misinterpret health information, may miss appointments, have questions that go unasked or remain unanswered, make ill-informed decisions, have health conditions that go unchecked or worsen, make medication errors, get lost in the healthcare system, or suffer adverse medical outcomes. The potential for harm is great!

Much health information, including web-based, is in print format. Often, vocabulary and language are used that are beyond the comprehension of many, if not most, Canadians. Several strategies can be used to help improve health illiteracy, including recognising the problem of health literacy, using plain language, adopting appropriate icons or visual models, and encouraging patients to ask questions. These strategies can be used by individual healthcare professionals and by institutions, and may contribute to improvements in healthcare safety.

This Pre-Conference will offer a broad perspective on the complex issues related to patients' comprehension and understanding in healthcare and specifically in healthcare safety. The program will feature a mixture of personal stories, theoretical concepts, research on health literacy, Canadian initiatives and success stories, and audience participation. Individuals with a special interest in healthcare communication, patient information, health literacy, and healthcare safety will benefit from attending.



Learning Objectives

At the end of this program, participants will be able to:

- Relate an example of a patient’s difficulties with respect to communication and comprehension.
- Describe the fundamentals of health literacy, numeracy, and the use of images, and their relationships to healthcare safety.
- Discuss the impact of mental models and cultural aspects of communication on communication and comprehension.
- Appraise and apply some of the established Canadian practices.
- Articulate some of the challenges and barriers in implementing safe patient-centered care communications.
- Compare and contrast different national perspectives on health literacy.

Program

All sessions will take place in Salle de bal est unless otherwise noted.

Pre-Conference Moderators:

Steven Lewis, Saskatoon, Saskatchewan

Régis Vaillancourt, Ottawa, Ontario

0730 - 0830 **Breakfast and Registration**
Foyer Salle de bal, Salon Drummond

0830 - 0845 **Welcome and Introductions**
Laurel Taylor, Ottawa, Ontario

0845 - 0930 **Why patients and providers don’t understand each other – and what we can all do to help**
Deborah Prowse, Calgary and Philip Hébert, Toronto
Despite our best efforts, communication between healthcare providers and patients is often less than optimal. In this presentation, Deborah Prowse, Patient Safety Advocate, will discuss Family Practitioner Philip Hébert’s experience as a patient. She will then comment on this story

0930 - 1000

Break

Foyer Salle de bal

1000 - 1130

“WHY DON’T I UNDERSTAND YOU?”

Literacy: More than words can say

Linda Shohet, Montréal, Quebec

The word “literacy” has recently come to mean something beyond reading and writing, and more of a metaphor for the ability to make meaning from symbols, whether words, numbers or visual images. Nevertheless, recent studies have shown that at least half of Canadians have difficulty with only the reading component. Linda Shohet will talk about how literacy connects to health and safety for individuals and for institutions and systems. She will suggest that improving health literacy over time can only be the outcome of an asymmetrical relationship, with the greater responsibility falling on providers and systems than on the client-users.

Calculating care: A consideration of health numeracy

Lorie Donelle, Waterloo, Ontario

Numeracy is one of the skills that contributes to overall health literacy and includes the ability to understand basic numbers, orders of magnitude, and probabilities. Low numeracy is known to contribute to poorer medical treatment and poorer health outcomes. In this presentation, Lori Donelle will provide an overview of numeracy within contemporary healthcare, highlighting numeric comprehension as an important contributor to self-health care and enhanced quality of care.

A picture is worth a thousand words

Régis Vaillancourt, Ottawa, Ontario

Evidence now shows the effectiveness of using images, or pictograms to improve communication. In this presentation, Régis Vaillancourt will provide a short historical perspective on the progression of communicating from image to text, the current use of images and symbols to communicate in the modern world, and the requirement and impact of using images and pictograms in clinical practice. He will also describe standards from the World Health Organization and from Europe, as well as the cultural sensitivity needed when using pictograms.

Contributors

Canadian Council on Learning, Canadian Patient Safety Institute, Centre for Literacy of Quebec, McGill University Health Centre, and Patients for Patient Safety in collaboration with the Halifax 9 Organizing Committee

Program Chairs

Co-chair: Laurel Taylor PhD

Director of Operations – Ottawa, Canadian Patient Safety Institute, Ottawa, Ontario

Co-chair: Mark Daly RRT MA(Ed)

Patient Safety Coordinator, McGill University Health Centre, Montréal, Quebec

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Chantale Audet

Responsable de la mise à jour et due développement, Mieux vivre avec, notre enfant de la grossesse à deux ans: From Tiny Tot to Toddler: Practical guide for parents from pregnancy to age two, L'Institut national de santé publique du Québec, Montréal, Quebec

Katarina Busija RN BN

Board Co-Chair and Patient for Patient Safety Champion, Patients for Patient Safety Canada (Branch of the World Alliance for Patient Safety's Patients for Patient Safety Program), Toronto, Ontario

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Nadine Valk

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Faculty

Visit the Symposium website for detailed biographies of our faculty.

Lorie Donelle RN PhD

Assistant Professor, Faculty of Health Sciences, University of Western Ontario, Waterloo, Ontario

Rhona Flin BSc PhD FBPsS FRSE

Professor, School of Psychology, University of Aberdeen, Old Aberdeen, Scotland

Philip Hébert

Associate Professor of Family Medicine, Bioethics Consultant, and Chair of the Research Ethics Board, Sunnybrook Health Sciences Centre; Faculty of Medicine, University of Toronto, Toronto, Ontario

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Executive Director, Manitoba Institute for Patient Safety, Winnipeg, Manitoba

Régis Vaillancourt PharmD

Director of Pharmacy, Children's Hospital of Eastern Ontario, Ottawa, Ontario

Michael Wolf PhD

Assistant Professor, Division of General Internal Medicine, Northwestern University, Chicago, Illinois

1130 - 1300	Lunch <i>Salon Drummond</i>	in healthcare. She will review evaluation results for <i>ISTA</i> , as well as how the initiative is being applied at the grass roots level in two projects in rural Manitoba. She will also provide highlights of other Canadian examples of health literacy initiatives.
1300 - 1400	TRANSLATING IDEAS The impact of mental models on communication and comprehension <i>Rhona Flin, Old Aberdeen, Scotland</i> Research from high-risk work sectors shows the critical interplay between cognition and communication, especially when conditions are less than ideal. Analysis of industrial accidents has demonstrated the powerful influence of mental models and resulting expectations on what is said and what is heard. In this presentation, Rhona Flin will examine the role of mental models and their influence on communication, with reference to safety critical tasks.	Putting health literacy on the agenda: The experience of the McGill University Health Center <i>Catherine Oliver, Montréal, Quebec</i> Catherine Oliver will describe the experience of the McGill University Health Centre (MUHC) in developing health literacy capacity. She will follow the process from the creation of the MUHC Patient Education Standards with a strong health literacy focus four years ago, to the current mentoring program, and 2009 launch of the Health Education Collection web-site which incorporates these Standards. Finally, she will discuss facilitators, challenges and next steps.
1400 - 1455	FINDING SOLUTIONS Add patients and stir: ‘It’s Safe to Ask’ and other Canadian examples <i>Laurie Thompson, Winnipeg, Manitoba</i> Have you wondered how to spark dialogue between patients and providers? What are the key questions a patient should ask about one’s healthcare? Do you know what health literacy initiatives are underway in Canada? What type of evaluation exists? How does one apply health literacy initiatives at the grassroots level? Laurie Thompson will discuss these questions and examine ‘ <i>It’s Safe to Ask</i> ’ (<i>ISTA</i>), a Manitoba provincial initiative. <i>ISTA</i> aims at improving patient safety by strengthening communication between Manitobans and their healthcare providers. Manitobans are being encouraged to ask three simple but important questions about their own care. This strategy should help to improve care, make care a positive experience, and reduce miscommunications leading to adverse events	1455 - 1520 Break <i>Foyer Salle de bal</i> 1520 - 1550 IMPLEMENTING AND SHARING SOLUTIONS In this session, participants will be invited to discuss their own challenges and solutions in implementing health literacy practices. Participants will also be given the opportunity to define required resources to improving health literacy in their organizations. 1550 - 1650 KEYNOTE Literacy and its impact on health: A summing up <i>Mike Wolf, Chicago, Illinois</i> In this presentation Mike Wolf will review research defining health literacy, including associations between adult literacy skills and health outcomes. He will examine these relationships in detail and discuss likely causal pathways, as well as questioning whether or not cognition may be the actual causal factor that adversely affects health behaviors and outcomes. Finally, he will explore the implications of health literacy research and evidence gathered in the field of cognitive epidemiology for clinical practice, education, and policy. 1650 - 1700 Final remarks <i>Steven Lewis, Saskatoon, Saskatchewan and Régis Vaillancourt, Ottawa, Ontario</i>

Halifax 9 Pre-Conference Event

Thursday, October 22, 2009

Pre-Conference 2 will be included in the Symposium webcast and DVD archive, pending permission from the speakers.

PRE-CONFERENCE 2

Designing with Safety in Mind

Program Overview

How do you incorporate safety into the design and construction of a new healthcare facility or a renovation? At this Pre-Conference you will learn how patient safety, staff safety and public health can be enhanced through the application of evidence-based design and an understanding of Human Factors. Facility planners, architects, engineers, designers, funders of capital projects, government planners and healthcare leaders will benefit from this one-day comprehensive meeting.

Learning Objectives

At the end of this program, participants will be able to:

- Outline ten steps that should be taken to ensure success in design of safer healthcare environment and the specific improvements that can be made in existing environments, including the use of a simple return on investment framework to measure the economic value of any design innovation.
- Summarize the history of hospital design, especially in respect to hygiene and hospital design.
- Review the role of hospital engineering and design in helping to ensure hygiene and assess its contribution to human performance.
- Examine the use of Human Factors and simulation in safe healthcare design.
- Discuss the first international Pebble Project construction of a new hospital and relate how Public-Private Partnerships influence design and affect safety.
- Describe how innovations in new hospital designs and healthcare delivery can contribute to a healing environment, safer care, and improved healthcare outcomes.
- Propose how clinicians can actively influence new designs for ICUs and associate new ICU and OR designs with their effect on healthcare safety and hygiene.



Program

All sessions will take place in *Salle de bal centre and ouest* unless otherwise noted.

Pre-Conference Moderators:
Micheline Ste-Marie, Montréal, Quebec
Blair L. Sadler, San Diego, California

1000 - 1030

Questions and Discussion Period

1030 - 1100

Break

Foyer Salle de bal

0800 - 0830 **Breakfast and Registration**
Foyer Salle de bal, Salon Drummond

1100 - 1200

EVIDENCE AND GUIDELINES

0830 - 0900 **Welcome and Introductions**
Micheline Ste-Marie, Montréal, Quebec

Hospital building design: Contributory factors in increased infection incidence

Graeme Gidney, Glasgow, Scotland

0900 - 0930 **The compelling strategic and business case for building safer healthcare environments**
Blair L. Sadler, San Diego, California

Many healthcare and architectural leaders do not understand the connection between evidence-based physical design and improved patient and workforce safety. Even fewer leaders realize the strong, long-term business case for proven design innovations. In this presentation, Blair Sadler will describe the vital role of healthcare leaders in ensuring that cost-effective design innovations are implemented. He will also outline ten steps that should be taken to assure success and the specific improvements that can be made in existing and new healthcare environments. Finally he will explain how to use a simple return on investment framework to measure the economic value of any design innovation.

Graeme Gidney will cover a risk-based approach to the design of hospital buildings to reduce the contributory factors for the incidence of hospital acquired infection incidence. He will aim to identify elements of hospital design that are claimed to have an impact on increased rates of hospital acquired infection and provide a proposal for a risk-based assessment tool that could be used to identify infection risk in existing buildings and areas for consideration in the design of new facilities. His presentation is based on a summary of his findings from his thesis, entitled *Infection control: a tool for sustainable hospital design*, carried out as part of a Masters Program at the University of Cambridge.

0930 - 1000 **Medicine by design: Lessons from the past, precautions for the future**
Annmarie Adams, Montréal, Quebec

Annmarie Adams' talk will draw from her recent book, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (University of Minnesota Press, 2008), which explores the impact of hospital design on early twentieth-century medicine. Presenting a wide range of visual imagery, she will link advances in twentieth-century hospital safety and hygiene to issues in contemporary healthcare design. Her case studies focus on the design of hospitals associated with McGill University, from the Royal Victoria Hospital of 1893 to the futuristic McGill University Health Centre, scheduled to open in 2013.

Developing evidence for hospital design using human factors and patient simulation methods

Jeff Caird, Calgary, Alberta

Human Factors principles for ease of use, access, safety and feedback are described in relation to the design of four primary room types at the South Health Campus (SHC) hospital in Calgary. A series of scenarios were developed, run, observed and analyzed using patients, nurses, doctors and support staff as they accomplished a range of procedures in mock-ups of an acute care room, an emergency exam room, an outpatient room and an intensive care (ICU) room. Code Blue and pediatric lumbar puncture scenarios used adult and pediatric patient simulators, respectively. Design recommendations for changes to the rooms, and executed by the architect and contractors, were based on Human Factors principles, coded observations and feedback from participants. Jeff Caird will discuss the effect of these new methods on architectural usability and patient safety.

Planning Committee

Co-chair: Jan Davies MSc MD FRCPC

Professor, Department of Anesthesia, Faculty of Medicine; Adjunct Professor of Psychology, Faculty of Social Sciences, University of Calgary, Calgary, Alberta

Co-chair: Micheline Ste-Marie MD

Associate Director of Professional Services, Montréal Children's Hospital, McGill University Health Centre, Montréal, Quebec

Faculty

Visit the Symposium website for detailed biographies of our faculty.

Annmarie Adams PhD, MRAIC

William C. Macdonald Professor and Associate Director, School of Architecture, McGill University, Montréal, Quebec

St. Clair Armitage

PPP Project Director, McGill University Health Centre, Montréal, Quebec

Jeff Caird PhD

Professor, Department of Psychology, University of Calgary, Calgary, Alberta

Luc Dubé PhD

Physicien médical, DSH, Centre Hospitalier de L'Université de Montréal, Montréal, Quebec

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Eva Thomas BSc MD PhD (Sweden) FRCPC

Clinical Professor, Department of Pathology & Laboratory Medicine, University of British Columbia, Vancouver, British Columbia

Rudi van den Broek BSc MPA

Chief Project Officer and General Manager of Special Projects, Vancouver Island Health Authority, Victoria, British Columbia

Jacqueline Vischer PhD

Professeure titulaire, École de design industriel, Faculté de l'aménagement, Université de Montréal, Montréal, Quebec

1200 - 1300

WORKING LUNCH

Lunch for this session will be a box lunch provided in the Salle de bal foyer, to be eaten in the Salle de bal centre and ouest.

Case study: Incorporating evidence-based design in an inpatient environment

Rudi van den Broek, Victoria, British Columbia

A new \$350m, 500 bed Patient Care Centre (PCC) is being built in Victoria, B.C and is the first international Pebble Project. The new hospital will offer the latest in patient care and medical technology and will aim to improve outcomes for patients and staff. To do so, the design of the PCC has incorporated all the proven, evidence-based design elements from a literature base of more than 1,500 studies. These studies have examined ways that design can reduce errors, infections and falls and length of stay. Design elements that have been demonstrated to improve overall safety and patient outcomes include the extensive use of single rooms, ceiling mounted patient lifts, large opening windows, and the use of art and other positive distractions. In this Working Lunch session, Rudi van den Broek will describe the PCC design as a case study of how architectural attributes can positively impact safety and outcomes and can lead to the achievement of strategic outcomes such as safer care and safer staff.

1300 - 1500

LESSONS FROM NEW DESIGNS

Healing environment and safety

Tye Farrow, Toronto, Ontario

In this presentation, Tye Farrow will describe some award-winning examples of hospital environments designed to speed recovery and reduce errors. He will discuss some of the critical do's and don'ts of designing safer hospitals for patients, staff and visitors. He will also illustrate how to apply innovative approaches to healthcare design, by drawing on the recent development of a product aimed at infection control.

The medical ward of the 21st Century

Andrea Robertson, Calgary, Alberta

Andrea Robertson will discuss the unique approach used to renovate an existing medical unit at the Foothills Medical Centre in Calgary. The process led to the development of the "Ward of the 21st Century". This innovative unit has succeeded in continuing to provide important educational lessons and to evolve following the

planning, construction and implementation of the unit. Key aspects of these lessons and changes include: infection and prevention control, Human Factors approaches to design and communication, and team communication issues, all of which are grounded in a quality and safety approach.

How can PPP's improve the patient experience and affect safety?

St. Clair Armitage, Montréal, Quebec

In this presentation St. Clair Armitage starts by describing PPPs, or Public-Private Partnerships, as a process that is only a means to an end. The desired end is ensuring better patient care, research and teaching. This improved result is achieved by a combination of providing clinicians with modern facilities and patients with a healing environment. Also vital is the updating of clinical procedures and processes to ensure that the patient is really at the centre of everything we do. If used well, then the PPP process facilitates these objectives.

1500 - 1515

Break

1515 - 1615

LESSONS FROM INNOVATION

Designing a Hypertech Operating Suite and an Intensive Care Unit: How these new design concepts improve patient safety and comfort

Luc Dubé, Montréal, Quebec

Luc Dubé will outline the efforts taken to overcome traditional Operating Room dilemmas, to reduce overcrowding, to improve efficiency and to increase patient safety while integrating cutting-edge technology. The Operating Room of the future (ORF) must provide a seamless state-of-the art surgical space for each specialized surgical team working side-by-side within the operating suite. It is essential to take into account the architectural concepts and the functional layout of each work area. A dedicated high-tech work area must be customized to accommodate the clinical and technical requirements of each surgical team (anesthesiologists, surgeons, respiratory therapists, residents, etc). Defining multiple high-tech work areas and connecting them in a strategic manner is also a challenge that must be met in order to avoid cross-circulation between them, during on-going procedures. SECPARS (Surgical Equipment Control and Picture Archiving and Routing Systems) and the Biomed Raceway, including the Biomed Hub Room, increase ergonomics and flexibility. Robotic cameras,

strategically mounted, reduce overcrowding and undue risks to the patient by allowing students and other observers to comfortably view the surgical field away from the patient area. Luc Dubé will also look at the the Intensive Care Unit, where three concepts have an impact on patient outcome: reverse osmosis water system dedicated to dialysis, service columns and a separate computer area with integrated IT-TDP architecture.

Renovations of a 25 year old Pediatric Intensive Care Unit at the B.C. Children's Hospital: What did and did not work

Eva Thomas, Vancouver, British Columbia

The Intensive Care Unit (ICU) is the heart of a pediatric hospital and must be centrally located with easy access to the Emergency Room, Diagnostic Imaging and the OR. In the last few decades, two different constraints – technological advances and emerging infectious diseases – have put pressure on both the space requirements and design of any Pediatric ICU (PICU). In this presentation, Eva Thomas will describe the design challenges encountered during a recent renovation of a PICU, where not only space but funding were limiting factors.

1615 - 1645 Managing functional comfort: How safe environmental design improves worker performance

Jacqueline Vischer, Montréal, Quebec

Jacqueline Vischer first outlines what is meant by functional comfort - that is, ways in which the physical environment supports users' tasks at work. The concept of functional comfort includes safety and well-being, as well as users' need to employ the physical environment as a tool to get work done. She gives examples of successful workspaces in which functional comfort needs are met, as well as unsuccessful options that can threaten worker satisfaction, well-being and ultimately safety. She concludes her presentation with principles that should be applied to the design of environments in which all people work – to ensure that they are safe, comfortable and effective.

1645 - 1700 Closing remarks

*Micheline Ste-Marie, Montréal, Quebec
and Blair Sadler, San Diego, California*



Video Presentations

The “Golden Safety Pin” Award

Needlestick Injuries: Prevention and Protocol

- Meghan Gilley*, BSC, University of British Columbia Medical School, Vancouver, BC
- Stephanie Wise*, BSCH, University of British Columbia Medical School, Vancouver, BC
- Stephan Malherbe, MB, ChB, FCA(SA), MMed, FRCPC, BC Children’s Hospital, Vancouver BC
- John Masterson, MD, FRCSC FACS DABU, University of British Columbia, Vancouver General Hospital, BC Children’s Hospital, Vancouver BC

*co-author

In Safe Hands

- Dorothy Jones, Curtin University, Faculty of Health Sciences

A Clinical Skills Video: The Open Gowning and Gloving Technique

- Simon Jones, University of British Columbia Medical School

A Clinical Skills Video: The Closed Gowning and Gloving Technique

- Simon Jones, University of British Columbia Medical School

Oh shnocks!: The state of healthcare technology in ‘09

- Tara McCurdie, Healthcare Human Factors Group, University Health Network, Toronto, ON
- Joe Cafazzo, Healthcare Human Factors Group, University Health Network, Toronto, ON
- Anjum Chagpar, Healthcare Human Factors Group, University Health Network, Toronto, ON

Teaching safe sharps handling in the operating room

- David Tso, BC Children’s Hospital, Vancouver, BC
- Monica Langer, BC Children’s Hospital, Vancouver, BC
- Sonia Butterworth, BC Children’s Hospital, Vancouver, BC

Webcast Sites

as of October 5, 2009

BRITISH COLUMBIA

BC Cancer Agency, Vancouver
BC Centre for Disease Control, Vancouver
BC Children’s Hospital and BC Women’s Hospital and Health Centre, Vancouver
Dawson Creek and District Hospital, Dawson Creek
Fort Nelson General Hospital, Fort Nelson
Fort St. John General Hospital, Fort St. John
GR Baker Memorial Hospital, Quesnel
Hudson’s Hope Health Centre, Hudson’s Hope
Kootenay Boundary Regional Hospital, Trail
North East Corporate Office, Fort St. John
Northern Health, Prince George
Office of the Chief Coroner, Burnaby
Riverview Hospital, Coquitlam
Thompson Cariboo Region, Kamloops
Tumbler Ridge Community Health Centre, Tumbler Ridge
Vancouver General Hospital, Centennial Pavilion, Vancouver
Vancouver General Hospital, Jim Pattison Pavilion, Vancouver

SASKATCHEWAN

Cypress Health Region, Swift Current
Kelsey Trail Health Region, Tisdale
Regina Qu’appelle Health Region, Regina
Sun Country Health Region, Weyburn
Saskatoon Health Region, Saskatoon

MANITOBA

Altona Community Health Centre, Altona
Assiniboine Community College, Dauphin
Bethesda Hospital, Steinbach
Boundary Trails Health Centre, Winkler
Brandon Regional Health Centre, Brandon
Burntwood Regional Health Authority, Thompson
Canad Inns Polo Park, Winnipeg
Carman Memorial Hospital, Carman
Churchill Regional Health Authority, Churchill
Interlake Regional Health Authority, Selkirk
NOR-MAN Regional Health Authority, Flin Flon
NOR-MAN Regional Health Authority, The Pas
NOR-MAN Regional Health Authority, Snowlake
Portage District General Hospital, Portage la Prairie
RHA Central Corporate Office, Southport
Riverview Health Centre, Winnipeg
Rock Lake Health District Hospital, Crystal City
Seven Regions Health Centre, Gladstone
St. Boniface General Hospital, Winnipeg
The Manitoba Pharmaceutical Association, Winnipeg

ONTARIO

Pembroke Regional Hospital, Pembroke

PRINCE EDWARD ISLAND

Prince County Hospital, Summerside

NOVA SCOTIA

Capital District Health Authority, Halifax
South Shore Health, Bridgewater
South West Health, Yarmouth

Abstracts

Full abstracts are available for print on the Symposium website.

1. THE SPECIMEN AND THE PATIENT: A SAFETY SOLUTION TO GETTING IT RIGHT
Tina Ackerman, Eastern Health
2. PATIENT SAFETY IN SAUDI HOSPITALS: ASSESSMENT OF PROVIDER'S PERCEPTIONS
Saad Alghanim, King Saud University
3. PARTNERING WITH PATIENTS AND FAMILIES TO BALANCE SAFETY AND AUTONOMY IN REHABILITATION AND COMPLEX CONTINUING CARE
Angie Andreoli, Toronto Rehab
4. ETHICS... BUT MY PROJECT IS EVALUATION OR QI, NOT RESEARCH!
Linda Barrett-Smith, Alberta Heritage Foundation for Medical Research
5. HURDLES TO SUCCESSFUL IMPLEMENTATION OF THE SURGICAL SAFETY CHECKLIST: A PILOT STUDY
Simon Bergman, Jewish General Hospital
6. MITIGATING RISK DURING HOSPITAL CONSTRUCTION PROJECTS: CHECK IT OUT
Cathy Bidwell, St. Michael's Hospital
7. MEDICATION RECONCILIATION ON ADMISSION TO A GERIATRIC PSYCHIATRY UNIT
MaryBeth Blokker, St. Joseph's Health Care London
8. PATIENT SAFETY IN MENTAL HEALTH
Lynda Bond, BC Mental Health and Addiction Services
9. NURSING ROUNDS SUPPORT PATIENT SAFETY INITIATIVES
Diane Brault, Jewish General Hospital
10. "PRE-LAB CSI: WHERE ARE THE RESULTS?"
Guna Budrevics, Sunnybrook Health Sciences Centre
11. PATIENT SATISFACTION SURVEYS: ASKING PATIENTS ABOUT MEDICATION DELIVERY
Paula P. Calestagne, Jewish General Hospital
12. INCORPORATING PATIENT FEEDBACK IN THE DESIGN OF A CANCER CENTRE
Paula P. Calestagne, Jewish General Hospital
13. SPEAKING THE SAME LANGUAGE, SHARING THE SAME PARADIGM: HELPING MAKE HEALTHCARE SAFER. PART 3
Deborah Cartwright, Alberta Health Services
14. IMPROVING PATIENT SAFETY DURING RADIATION THERAPY USING HUMAN FACTORS METHODS
Alvita Chan, University Health Network
15. ENHANCING COLLABORATION IN THE CLINICAL LEARNING ENVIRONMENT
Christina Clausen, School of Nursing, McGill University
16. KNOWLEDGE AND ATTITUDES OF PAEDIATRIC RESIDENTS TOWARD DISCLOSURE OF ADVERSE EVENTS
Trey Coffey, University of Toronto and Hospital for Sick Children
17. DEVELOPMENT AND EVALUATION OF A PATIENT SAFETY EDUCATION PROGRAM FOR PATIENTS
Joanne Copeland, St. Michael's Hospital
18. HUMAN FACTORS EVALUATION OF SMART INFUSION PUMPS: AN IMPORTANT TOOL IN THE PROCUREMENT PROCESS
Patti Cornish, Sunnybrook Health Sciences Centre
19. ROAMERS, ROAD SHOWS AND BOOT CAMPS: AN INNOVATIVE APPROACH TO LEARNING AND CHANGE MANAGEMENT
Linda Cumming, BC Patient Safety and Learning System
20. IMPROVING PATIENT SAFETY THROUGH ACCREDITATION
Christopher Dean, Accreditation Canada
21. HOSPITAL-WIDE, SINGLE-DAY AUDIT OF THROMBOPROPHYLAXIS USE
Artemis Diamantouros, Sunnybrook Health Sciences Centre
22. IMPROVING PROCESSES FOR ENDOSCOPY THROUGH PROSPECTIVE ANALYSIS
Annette Down, Lakeridge Health Corporation
23. DISCLOSURE PAMPHLET: AN ESSENTIAL TOOL FOR PATIENTS, STAFF & FAMILIES
Lianne Dzygala, Jewish General Hospital
24. HOSPITAL-WIDE PATIENT IDENTIFICATION SAFETY INITIATIVES
Lianne Dzygala, Jewish General Hospital
25. CRITICAL INCIDENT REVIEWS: A PROCESS AIMED AT IMPROVING PATIENT SAFETY IN THE HOSPITAL SYSTEM
Lianne Dzygala, Jewish General Hospital
26. IMPLEMENTATION OF THE NATIONAL SAFER HEALTHCARE NOW! VENOUS THROMBOEMBOLISM INTERVENTION IN A MONTREAL HOSPITAL
Jessica Emed, Jewish General Hospital
27. DEVELOPMENT OF A FALL PREVENTION PROGRAM IN A TEACHING HOSPITAL: AN INTERDISCIPLINARY PATIENT SAFETY INITIATIVE
Jessica Emed, Jewish General Hospital
28. MEASURING THE IMPACT OF HUMAN FACTORS INFORMED TRAINING ON THE SAFETY AND EFFICIENCY OF SMART INFUSION TECHNOLOGY
Mark Fan, Institute of Biomaterials and Biomedical Engineering, University of Toronto
29. MEDICATION RECONCILIATION: IN-PATIENT & OUT-PATIENT SETTINGS - FORGING NEW TERRITORY WITH AMBULATORY CARE
Suzanne Fuller Blamey, BC Cancer Agency, Provincial Health Service Authority
30. DEVELOPING A SAFE TRANSFER COMMUNICATION PROCESS: A SIMPLE SOLUTION TO COMPLEX PATIENT CARE
Louise Fullerton, McGill University Health Centre (MUHC)
31. RESTRAINT REDUCTION IN GERIATRICS: DREAM OR REALITY?
Brigitte Galand, Ste. Anne's Hospital
32. THE GREAT CANADIAN VTE AUDIT: A NATIONAL THROMBOPROPHYLAXIS SURVEY
William Geerts, Safer Healthcare Now!; Sunnybrook Health Sciences Centre; University of Toronto

33. PUBLIC REPORTING OF CDAD SURVEILLANCE IN ONTARIO
Debbie Gibson, Ministry of Health and Long-term Care
34. DEVELOPING A CULTURE OF SAFETY IN A LONG-TERM CARE FACILITY THROUGH FALL PREVENTION
Jacqueline Gilbert, Jewish Eldercare Centre
35. ENVIRONMENTAL CONTAMINATION AND OCCUPATIONAL EXPOSURE TO CYTOTOXIC DRUGS IN AN ONCOLOGY PHARMACY SATELLITE
Geneviève Goulet, Children's Hospital of Eastern Ontario
36. THE EVOLUTION OF THE SURGICAL SAFETY CHECKLIST: THE TORONTO STORY
Gillian Gravely, Toronto General Hospital, University Health Network
37. SAFETY CULTURE IN HEALTHCARE: A REVIEW OF CONCEPTS, INDICATORS, MEASURES AND PROGRESS
Michelle Halligan, University of Western Ontario
38. CONDUCTING A BEST POSSIBLE MEDICATION HISTORY AND RESOLVING MEDICATION DISCREPANCIES IN THE COMMUNITY
Certina Ho, Institute for Safe Medication Practices Canada (ISMP Canada)
39. TRANSFER OF ACCOUNTABILITY-SAFE PATIENT HANDOFF
Marcella Honour, Trillium Health Centre
40. SPEAKING THE SAME LANGUAGE, SHARING THE SAME PARADIGM: HELPING MAKE HEALTHCARE SAFER. PART 2
Sherryl Hoskins, Alberta Health Services
41. PRESENCE-OF-QUALITY: PATIENT-CENTERED PLANNING FOR ENHANCED PATIENT SAFETY – THE PATIENT'S PERSPECTIVE
Richard Hovey, Consumers Advancing Patient Safety (CAPS)
42. MAIMONIDES GERIATRIC CENTRE'S "SUITE DREAMS" CAMPAIGN: A QUALITY IMPROVEMENT PROJECT
Stefania Iapaolo, Maimonides Geriatric Centre
43. PATIENT SAFETY REPORTING: A CRITICAL CARE PROGRAM'S EXPERIENCE
Roy Ilan, Queen's University, Kingston General Hospital
44. SAFETYNET: AN ORGANIZATIONAL APPROACH TO IMPROVING ADVERSE EVENT REPORTING AND SAFETY CULTURE
Lianne Jeffs, St. Michael's Hospital
45. BUILDING KNOWLEDGE FOR SAFER HEALTH CARE: THE NURSING RESEARCH ADVANCING PRACTICE (RAP) PROGRAM
Lianne Jeffs, St. Michael's Hospital
46. OPTIMIZING THE USABILITY OF THE MEDICATION HISTORY REPORT TO INCREASE PATIENT SAFETY
Sunil Kadikar, West Park Healthcare Centre – Shared Information Management Services (SIMS)
47. A SYSTEMS APPROACH TO UNDERSTANDING THE CULTURAL BARRIERS TO IMPROVING INFECTION CONTROL COMPLIANCE
Judy Kojlak, London Health Sciences Centre
48. COLLABORATIVE EFFORTS ADDRESS SAFETY CONCERNS IN ELECTRONIC MEDICATION ORDER ENTRY SYSTEM
Miranda Kutnjak, West Park Healthcare Centre
49. EXPLORING MEDICATION SAFETY IN HOMECARE WITH A SOCIO-ECOLOGICAL LENS: AN INNOVATIVE VISUAL RESEARCH PROTOCOL
Ariella Lang, VON Canada
50. FACILITATING PATIENT SAFETY LEARNING IN THE WORKPLACE
Christine Leach, Alberta Health Services – Cancer Corridor (formerly Alberta Cancer Board)
51. MAIMONIDES INTERPROFESSIONAL PROCESS PROGRAM: SHARED DECISION MAKING IN IMPROVING RESIDENT CARE & SAFETY
Paula Levinson, Maimonides Geriatric Centre
52. PHYSICIAN COMMUNICATION BARRIERS TO SHARED UNDERSTANDING AND SHARED DECISION-MAKING: IMPLICATIONS FOR PATIENT SAFETY
Brenda Lovell, University of Manitoba
53. THE SAFER (STUDYING ADVERSE EVENTS FROM ELECTIVE SURGERY RESEARCH) PROJECT: FEASIBILITY AND PILOT STUDY
Norman MacDonald, Dalhousie University
54. REQUIRED ORGANIZATIONAL PRACTICES – FROM MANDATE TO REALITY
Pauline MacDonald, Capital Health
55. USING SIMULATION TO ENHANCE PATIENT SAFETY THROUGH INTERPROFESSIONAL CARE
Kathleen MacMillan, Humber Institute of Technology and Advanced Learning
56. EXPLORATION OF NEAR MISSES IN MENTAL HEALTH SETTINGS
Kathleen MacMillan, Humber Institute of Technology and Advanced Learning
57. USING RESEARCH TO TRANSFORM CLINICAL LEARNING ENVIRONMENTS: A COLLABORATIVE CLINICAL LEARNING UNIT PILOT
Patricia Marck, University of Alberta
58. MISTAKE-PROOFING IV MEDICATION ADMINISTRATION WITH THE USE OF SMART PUMPS
Aline Markarian, Jewish General Hospital
59. HUMAN FACTORS EVALUATIONS: EVIDENCE-BASED DESIGN AND SAFETY GUIDANCE FOR EMERGENCY DEPARTMENT EXAM ROOMS
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60. A HUMAN FACTORS EVALUATION OF CHEMOTHERAPY MEDICATION LABELS
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61. CLINICAL INFORMATION SYSTEMS – A HUMAN FACTORS APPROACH TO ASSESSMENT
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62. EVALUATING AN INTEGRATED DISCLOSURE INITIATIVE: PHASE 1
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63. WEST PARK HEALTHCARE CENTRE'S SYSTEMATIC APPROACH TO IMPROVING ALLERGY DOCUMENTATION IN THE ELECTRONIC PATIENT RECORD
Candice Newell, West Park Healthcare Centre/Shared Information Management Services (SIMS)
64. THE PATIENT EDUCATION NETWORK WORKING GROUP (PEN): A HOSPITAL-BASED INTERPROFESSIONAL COLLABORATION TO FOSTER PATIENT EDUCATION
Maggie Newing, Jewish General Hospital

65. MEDICAL SAFETY IN COMMUNITY PRACTICE — IMPROVEMENT STRATEGIES
Maeve O'Beirne, University of Calgary
66. IMPROVING QUALITY OF CARE AND WORK ENVIRONMENTS THROUGH INTERDISCIPLINARY WORK REDESIGNS
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67. IMPLEMENTING AND SUSTAINING PRACTICE CHANGES FOR PATIENT SAFETY IN 5 HOSPITALS
Patricia O'Connor, McGill University Health Centre
68. OFF-LABEL DRUG USE IN CRITICAL CARE PEDIATRICS
Elena Pascuet, Children's Hospital of Eastern Ontario
69. AUTOMATED UNIT DOSE: REDUCING VARIANCES IN MEDICATION ADMINISTRATION
Fruzsina Pataky, Vancouver Coastal Health; Providence Health Care Pharmacy Services
70. IMPLEMENTATION EVALUATION: IMPACT OF CHANGE FROM A NON-CONFIDENTIAL PATIENT SAFETY REPORTING SYSTEM TO A CONFIDENTIAL SYSTEM
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71. GRADUATED COMPRESSION STOCKINGS FOR VENOUS THROMBOEMBOLISM PREVENTION: A POLICY AND PROCEDURE TO IMPROVE PATIENT SAFETY
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72. AN OBSERVATIONAL STUDY OF INTERRUPTIONS TO NURSES DURING ADMINISTRATION OF AMBULATORY CHEMOTHERAPY
Varuna Prakash, Centre for Global eHealth Innovation, University Health Network
73. BARRIERS TO ADVERSE EVENT REPORTING FOR HOSPITAL SUPPORT STAFF
Amna Qureshi, Cognitive Ergonomics Research Lab, University of Calgary
74. DESIGNING A FALL PREVENTION PROGRAM IN LONG TERM CARE: AN INTERDISCIPLINARY APPROACH, A MULTIFACTORIAL INTERVENTION
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75. DESIGNING WITH SAFETY: MANAGEMENT OF OSTEOPOROSIS IN FRAGILITY HIP FRACTURE PATIENTS
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76. A PATIENT SAFETY POLICY AWARENESS STRATEGY
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77. COLLABORATIVE WARFARIN MANAGEMENT IN LONG TERM CARE
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78. SPEAKING THE SAME LANGUAGE, SHARING THE SAME PARADIGM: HELPING MAKE HEALTHCARE SAFER. PART 1
Chris Sargent, Alberta Health Services
79. CANADIAN PHARMACEUTICAL BAR CODING PROJECT
Ian Sheppard, ISMP Canada
80. PATIENT SAFETY IN DAY HOSPITAL TRANSITION
Linda Smyrski, Manitoba Health
81. AIR-OXYGEN MISCONNECTION: REMOVAL OF AIR FLOW METERS AS A SOLUTION
Gerald Spence, Alberta Health Services
82. REFORMING PRISON DESIGN: INTERRELATIONSHIPS BETWEEN PRISON ENVIRONMENTS AND THERAPEUTIC PROGRAMMES: A COMPARATIVE STUDY OF HMP GRENDON AND HMP DOVEGATE, ENGLAND UK
Rona Stephen, Edinburgh Napier University
83. IMPLEMENTING BC PATIENT SAFETY & LEARNING SYSTEM: A CENTRALIZED APPROACH TO PROVINCIAL SPREAD AND ADOPTION
Annemarie Taylor, BC Patient Safety and Learning System
84. CREATING A CULTURE OF SAFETY AND QUALITY: DATA DRIVEN DECISION MAKING NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM AT SURREY MEMORIALHOSPITAL
Angela Tecson, Surrey Memorial Hospital
85. READY, SET, GO ... GETTING TO GREEN IN THE ACCREDITATION CANADA QMENTUM PROCESS
Beverley Tezak, Lakeridge Health Corporation
86. ANALYSE DE L'INFLUENCE DES VALEURS ORGANISATIONNELLES ET DE LA QUALITÉ DE VIE AU TRAVAIL SUR LA QUALITÉ ET LA SÉCURITÉ DES SOINS
Georges Thiebaut, Université de Montréal; Rassemblement pour l'amélioration de la qualité et de la sécurité de soins de l'université de Montréal (RAQSSUM)
87. VIDEO-BASED STUDY OF COMMUNICATION DURING HANDOVERS: HOW DO ICU PHYSICIANS USE SBAR?
Eva To, Queen's University, Kingston General Hospital
88. SIGNIFICANT EVENT ANALYSIS — CHANGING CULTURE ONE ANALYSIS AT A TIME
Carolyn Trumper, Alberta Health Services
89. HEALTH CANADA'S PILOT FOR MEDICAL DEVICE ADVERSE EVENT REPORTING AND COLLABORATION ON SAFETY INITIATIVES.
Colleen Turpin, Marketed Health Products Directorate, Health Canada
90. ACHIEVING SAFER CARE THROUGH THE DEVELOPMENT OF A CASE BASED ONLINE ENVIRONMENT FOR INTERPROFESSIONAL EDUCATION
Mary van Soeren, Canadian Health Care Innovations
91. RISKS FOR FALLS USING INFORMATION FROM THE RESIDENT ASSESSMENT INSTRUMENT — MINIMUM DATA SET (RAI-MDS)
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92. AN INNOVATIVE APPROACH TO STUDYING RISKS AND PREVENTION OF TRANSFER RELATED FALLS IN LONG TERM CARE
Edgar Vieira, University of Alberta
93. AN ORGANIZED APPROACH TO BRIDGING THE SAFETY MANAGEMENT GAP
Susan Ward, Bay Area Health Trust
94. SAFETY IN HOME AND CONTINUING CARE: ENHANCING HUMAN PERFORMANCE WITH NEW DECISION-SUPPORT TOOLS
Nancy White, Canadian Institute for Health Information
95. IMPLEMENTATION OF ELECTRONIC CLINICAL DOCUMENTATION
Gail Wilson, St-Michael's Hospital
96. FALLS CAN HELP IMPROVE HEALTHCARE SAFETY: POTENTIAL OF SYSTEMIC FALLS INVESTIGATIVE METHOD (SFIM)
Aleksandra Zecevic, University of Western Ontario
97. DEATH AND ADVERSE EVENT REVIEW AT HAMILTON HEALTH SCIENCES
Rosanne Zimmerman, Hamilton Health Sciences