

CERTIFICATE IN PATIENT SAFETY & QUALITY

COURSE OVERVIEW
September 16, 2011

FALL 2011 SESSIONS
September 20-December 13

WINTER 2012 SESSIONS
January 10-February 21

PRESENTATION DAY
March 13, 2012

A course designed for healthcare professionals who want to expand their working understanding of concepts in patient safety and quality

W21C, TRW Building
Ground Floor
University of Calgary
Faculty of Medicine
3280 Hospital Drive NW
Calgary, AB



**REGISTRATION LIMITED TO
30 PARTICIPANTS**



*Office of Continuing Medical Education
and Professional Development*

CREATING THE FUTURE OF HEALTH

COURSE DETAILS

- The course will take place biweekly on Tuesday evenings, 6-9:30pm, starting September 20, 2011, ending March 6, 2012; dinner will be served starting at 5:30pm
- There will also be two all-day sessions on September 16, 2011 and March 13, 2012
- Participants will be expected to complete a project under the mentorship of Course Faculty members
- Participants will be eligible for continuing education credits

COURSE REQUIREMENTS

The Patient Safety & Quality certificate will be granted upon successful:

- Attendance at the two all-day sessions
- Participation during the twelve biweekly sessions (minimum of 9 evening sessions must be attended)
- Completion of a satisfactory project report and a presentation of the findings

LEARNING OBJECTIVES

- Distinguish and describe the components of a healthcare safety & quality model
- Describe core principles of patient safety & quality
- Identify key strategies for designing and delivering safer / higher quality healthcare
- Explain the critical role that microsystem and macrosystem leadership has for patient safety & quality
- Describe how a healthcare system should respond when the outcomes of healthcare design and delivery are not optimal
- Develop and present a patient safety / quality project

OUTLINE

COURSE OVERVIEW

SEPTEMBER 16, 2011

Patient Safety & Quality – Background

- History
- Epidemiology
- Models
- Principles

W Flemons

Patient Safety & Quality – Project

- Overview / expectations / timelines
- Effective problem or issue statements / Project outline
- Ethics
- Accessing the medical literature

M Harvie, M O'Beirne, D Wright

SESSIONS

Module 1: DESIGN

SEPTEMBER 20, 2011

Designing healthcare for optimal outcomes (I)

- Identifying opportunities to improve
- Clinical microsystems
- Prioritizing opportunities
- AHS Improvement Way

J Holroyd, M Harvie

OCTOBER 4, 2011

Designing healthcare for optimal outcomes (II)

- Applied QI research design
- Qualitative methods
- Administrative data

T Stelfox, A Harrison, W Ghali

OCTOBER 18, 2011

Designing healthcare for optimal outcomes (III)

- Quality improvement tools
 - PDSA
 - Lean Six Sigma
- Real-time quality management
 - Monitoring – statistical process control

D Brewin

NOVEMBER 1, 2011

Designing healthcare for optimal outcomes (IV)

- Clinical informatics / Clinical decision support
- Incorporating best-evidence into interventions
- Developing evidence denovo
- Knowledge transfer

J Holroyd, M O'Beirne

NOVEMBER 15, 2011

Designing healthcare for optimal outcomes (V)

- Human factors
- Understanding success and failure in healthcare

J Davies, J Caird

Module 2: DELIVER

NOVEMBER 29, 2011

Delivering optimal care (I)

- Patient engagement

A Harrison

DECEMBER 13, 2011

Delivering optimal care (II)

- Healthcare literacy and numeracy
- Information and informed consent
- Shared decision-making

T Ricento, W Flemons

Patient Safety & Quality – Project

- Structuring and writing a project report

M Harvie

JANUARY 10, 2012

Delivering optimal care (III)

- Communication
- Teamwork / Crew resource management

J Davies, D Musson

Module 3: RESPOND

JANUARY 24, 2012

Responding when healthcare delivery and outcomes are not optimal (I)

- Analyzing adverse events and close calls

C Duchscherer

Patient Safety & Quality – Project

- Structuring and writing a project report

M Hofmeister

FEBRUARY 7, 2012

Responding when healthcare delivery and outcomes are not optimal (II)

- Immediate management
- Supporting patients and healthcare providers
- Reporting
- Informing

B MacLeod, G McRae

FEBRUARY 21, 2012

Responding when healthcare delivery and outcomes are not optimal (III)

- Disclosure

B MacLeod, G McRae

MARCH 6, 2012

Leadership

- Individual and team leadership
- Organizational leadership

D White

Patient Safety & Quality – Project

- Preparing for presentation day

M Harvie, W Flemons

PRESENTATION DAY

MARCH 13, 2012

COURSE OVERVIEW DETAILS

SEPTEMBER 16, 2011 (Friday 8am-4pm)

Patient Safety & Quality – Background

Lead – W Flemons

LEARNING TOPICS

- 1) History
- 2) Epidemiology
- 3) Models
- 4) Principles

OVERVIEW OF THE SESSION

The safety and quality improvement (management) ‘movements’ evolved separately for many years and only recently have started evolving together in what might best be described as an awkward, poorly defined relationship. This session will trace the story lines of these important aspects of patient care and describe an approach for joining them together through the use of a theoretical model. By tracing the patient safety story line, this session will explore the data that is available about the incidence of adverse events in healthcare; this information is often used to justify changing the current approach of delivering care to patients. During this session, the case will be made that the actions of, or decisions made by, individuals and/or organizations to change (improve) the state of healthcare delivery should be based on sound safety and quality principles.

LEARNING OBJECTIVES

Upon completion of this session the participant will be able to:

- Compare and contrast the introduction / evolution of industrial safety models and industrial quality management models into healthcare
- Recall the estimated incidence of adverse events in healthcare from the important published studies and state the limitations of these studies
- List 6 principles of safety and quality management and be able to justify the rationale for their inclusion in a patient safety / quality framework and a theoretical model

Patient Safety & Quality – Project

Leads – M Harvie, M O’Beirne, D Wright

LEARNING TOPICS

- 1) Overview / expectations / timelines
- 2) Effective problem or issue statements / Project outline
- 3) Ethics
- 4) Accessing the medical literature

OVERVIEW OF THE SESSION

The project component of the course is an opportunity for participants to delve deeper into a particular topic area and apply what they have learned in the course to their local/work context. This session will describe what is expected of participants with respect to successfully completing and presenting a patient safety / quality improvement project. Because there are often ethical issues created by the desire to improve a system of care delivery, guidelines for when and how to engage in an ethics review process for a proposed intervention will be covered as well as looking at issues related to consent and managing data collected during a project. Finally, because it is the expectation that projects will cover a discussion of what is currently known about the topic area, participants will be introduced to methods for effectively searching the healthcare literature.

LEARNING OBJECTIVES

Upon completion of this session the participant will be able to:

- Describe the expectations for completing a course project
- Construct an effective problem statement for their project
- Describe ethical issues that can exist with patient safety/QI projects and the role of ethics review and consent in these types of projects
- Conduct a literature search using well established electronic databases
- Describe what ‘gray literature’ is

SESSION DETAILS

Module 1: DESIGN**SEPTEMBER 20, 2011** (Tuesday 6-9:30pm)**Designing healthcare for optimal outcomes (I)***Leads – J Holroyd, M Harvie*

LEARNING TOPICS

- 1) Identifying opportunities to improve
- 2) Clinical microsystems
- 3) Prioritizing opportunities
- 4) AHS Improvement Way

OVERVIEW OF THE SESSION

Improving the delivery of healthcare starts with a focus on identifying the best opportunities for making a positive change. This session will review the healthcare system structure (with a focus on microsystems) and then examine team building and developing key partnerships before discussing how to target an intervention. Several sources of 'inputs' will be explored including chart audits, trigger events, administrative data, incident report data, and process mapping to determine where a safety / QI intervention is needed and what population to target. The session will then look at: 1) how to ensure that an appropriate question has been asked (what is the objective and specific aims of the safety / QI intervention?); 2) how to define the current clinical process; and 3) how to target and prioritize the change(s) to make within the current clinical process in order to achieve objective and specific aims.

Alberta Health Services has developed an improvement method for staff and providers to use to improve the systems in which they work. A brief background overview of what the AHS Improvement Way is and how it could be used will be discussed.

LEARNING OBJECTIVES

Upon completion of this session the participant will be able to:

- Develop an approach to designing safety / QI interventions
- Define a clinical microsystem
- Describe approaches for prioritizing improvement opportunities
- Describe the AHS Improvement Way

OCTOBER 4, 2011 (Tuesday 6-9:30pm)**Designing healthcare for optimal outcomes (II)***Leads – T Stelfox, A Harrison, W Ghali*

LEARNING TOPICS

- 1) Applied QI research design
- 2) Qualitative methods
- 3) Administrative data

OVERVIEW OF THE SESSION

Testing interventions that have been proposed as a solution for a particular issue or problem can be challenging. This session will explore methods for investigating how effective a particular intervention actually is. An important aspect of gathering evidence is designing an appropriate evaluation. Measurement is a key aspect of evaluation and can be addressed through quantitative or qualitative methods – both approaches will be explored in this session.

Not all questions about quality and safety issues need to be uncovered with *de novo* data. Administrative data is captured routinely as part of the care of patients and can often shed important insights into

the quality and safety of the care provided to populations of patients. This session will introduce participants about how to use data of this type to generate and answer certain types of questions about the quality and safety of healthcare delivery.

LEARNING OBJECTIVES

Upon completion of this session the participant will be able to:

- Describe and select an appropriate experimental / quasi-experimental research design to answer a specific problem or issue
- Describe the relative strengths and weaknesses of different types of designs
- Define, explain and use qualitative methods
- Contrast quantitative and qualitative research
- Describe sources and uses of administrative data

OCTOBER 18, 2011 (Tuesday 6-9:30pm)**Designing healthcare for optimal outcomes (III)***Lead – D Brewin*

LEARNING TOPICS

- 1) Quality improvement tools
 - PDSA
 - Lean Six Sigma
- 2) Real-time quality management
 - Monitoring – statistical process control

OVERVIEW OF THE SESSION

The monitoring of quality, identifying opportunities for improvement through analysis of issues, and making improvements, are key steps in the cycle of Quality Management. In the healthcare delivery environment this cycle repeats indefinitely, and therefore healthcare professionals use practical tools to work through this process.

This module will introduce participants to practical tools, primarily Lean Six Sigma, for improving process/quality as well as introduce ideas and techniques to manage the quality of real time operations. As today's most prominent practical QI toolset, Lean Six Sigma is quickly becoming a common language for healthcare professionals and leaders. This session provides an introduction to the basic tools and techniques used in Lean Six Sigma quality improvement projects and contrasts this with the PDSA methodology.

Healthcare is a 24x7 business and decisions about patient care and flow need to be made on the fly. This is why each quality process should be designed with the adjoining process for monitoring and maintaining this quality in operations. This session will explore industry and healthcare methods and tools for process quality control and management.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Define the quality management cycle
- Discuss the stages of a Lean Six Sigma QI project and the basic Lean Six Sigma toolset
- Identify opportunities for Lean Six Sigma quality improvement initiatives
- Actively participate in and/or sponsor Lean Six Sigma projects
- Identify opportunities to gain formal training on Lean Six Sigma
- Describe the PDSA cycle and contrast this approach for quality improvement to Lean Six Sigma
- Identify opportunities and appropriateness for real-time quality control monitoring in healthcare

SESSION DETAILS

NOVEMBER 1, 2011 (Tuesday 6-9:30pm)

Designing healthcare for optimal outcomes (IV)

Leads – J Holroyd, M O’Beirne

LEARNING TOPICS

- 1) Clinical informatics / Clinical decision support
- 2) Incorporating best-evidence into interventions
- 3) Developing evidence denovo
- 4) Knowledge transfer

OVERVIEW OF THE SESSION

An important aspect of making changes to healthcare delivery is ensuring that where it is available, evidence informs the decisions that are made. This session will explore how to develop interventions that incorporate best research evidence and what to do when there is no evidence. The session will also review the use of knowledge translation (KT).

The role of clinical informatics will be reviewed including examination of: 1) the use of data from EMR/EHR to determine the Safety/QI question; 2) the use of clinical decision support (CDS) as part of the solution/intervention; 3) the use of EMR/EHR data to evaluate the outcomes of the Safety/QI intervention.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Find, evaluate and incorporate best evidence into Patient safety/QI interventions
- Describe the role of electronic data in Patient safety/QI interventions
- Create new information that provides evidence of how important an issue actually is or how effective an intervention is
- Define knowledge transfer and describe why it is an important part of quality / safety management

NOVEMBER 15, 2011 (Tuesday 6-9:30pm)

Designing healthcare for optimal outcomes (V)

Leads – J Davies, J Caird

LEARNING TOPICS

- 1) Human factors
- 2) Understanding success and failure in healthcare

OVERVIEW OF THE SESSION

Traditionally in healthcare, humans have played the central role in influencing how care is delivered and/or received. In the last decade or so, formal understanding of this role has grown, with the introduction of the specialty of Human Factors to healthcare and patient safety. Interest in Human Factors continues to grow. However, despite the interest in HF, there are suggestions that the extent of knowledge and skills pertaining to the specialty of HF is not completely appreciated. For example, HF covers more than the topics of ‘fatigue’ or ‘team work’. Allied with the topic of HF is the concept of studying both failure (as is typically done in healthcare), as well as success, which may yield lessons that are more easily assimilated, in part because of the absence of one or more patients suffering harm.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Give a definition, describe the origins, and list the goals of Human Factors
- Reproduce and describe a simple model of information processing

- Reproduce and describe at least one of three models of Human Factors – the SHEL, Reason & Winnipeg models
- List at least five factors that may influence human performance (Illness, Medication, Stress, Alcohol, Fatigue, Eating)
- Summarize the role of usability studies in day-to-day life and healthcare, as well as in the formal review of equipment before and after procurement
- Discuss the role of usability studies in the design of the workplace, such as the medication area, the Operating Room, and the Intensive Care Unit

Module 2: DELIVER

NOVEMBER 29, 2011 (Tuesday 6-9:30pm)

Delivering optimal care (I)

Lead – A Harrison

LEARNING TOPICS

- 1) Patient engagement

OVERVIEW OF THE SESSION

This session will provide an introduction to the literature on Patient / Family Centred Care (P/FCC) and the important link between engaging patients and the safety / quality of healthcare that is delivered. The session will cover ideas and practical examples for including patients and families at the bedside, in programs, and in system planning and evaluation.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Apply the literature on Patient and Family Centred Care (P/FCC) to enhance the safety and quality of care that is delivered
- Demonstrate ways to engage patients and families in all levels of health care
- Identify ways to implement P/FCC in their own environment / context

DECEMBER 13, 2011 (Tuesday 6-9:30pm)

Delivering optimal care (II)

Leads – T Ricento, W Flemons

LEARNING TOPICS

- 1) Healthcare literacy and numeracy
- 2) Information and informed consent
- 3) Shared decision-making

OVERVIEW OF THE SESSION

It is difficult, if not impossible to have patients fully engaged in their own healthcare if they do not adequately understand the information that is being conveyed to them. This session will introduce what is understood about patients’ lack of understanding of healthcare terminology and concepts (literacy and numeracy), the barrier this creates for engaging patients, and some strategies for addressing these issues.

The session will also introduce other aspects of effective communication between providers and patients, including information sharing and informed consent and the implications this has for shared decision-making and safer patient care.

SESSION DETAILS

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Define healthcare literacy and numeracy
- Describe the reasons for the gap between what patients are told and what they understand
- Explore strategies for improving the quality of information provided to patients and their understanding of that information
- Describe an informed consent process
- Justify the position that shared-decision making contributes to safer patient care

Patient Safety & Quality – Project

Lead – M Harvie

LEARNING TOPICS

- 1) Structuring and writing a project report

OVERVIEW OF THE SESSION

Successful completion of the course requires a written report of the project that the student has worked on. This session will highlight the expectations for the report. It will also provide recommendations for how to structure the report and guidelines for how it might be written.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Write a well structured and focused report on a quality improvement / patient safety topic

JANUARY 10, 2012 (Tuesday 6-9:30pm)**Delivering optimal care (III)**

Leads – J Davies, D Musson

LEARNING TOPICS

- 1) Communication
- 2) Teamwork / Crew resource management

OVERVIEW OF THE SESSION

Communication influences working groups and team formation, maintenance and function. In turn, working groups and teams form the basis of most healthcare interactions.

However, while every one of us communicates, some of us communicate less well than others. In this session, participants will be presented with the basics of communication and the importance of communication in healthcare safety.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- List the basic behavioural characteristics that facilitate and those that hinder optimal communication and to distinguish between different types of communication-related behaviours appropriate to different cultures and conditions
- Detail a model of communication based on information processing
- Describe the influence of communication in events leading to, or nearly leading to, patients being harmed
- Place communication in the spectrum of non-technical skills, which pertain not only to healthcare professionals but also to those working in other safety-critical domains, such as aviation
- List the pros and cons of adjuncts to communication, such as Situation-Background-Assessment-Recommendation (SBAR)
- Outline the basics of working groups and team formation, maintenance and function

Module 3: RESPOND**JANUARY 24, 2012** (Tuesday 6-9:30pm)**Responding when healthcare delivery and outcomes are not optimal (I)**

Lead – C Duchscherer

LEARNING TOPICS

- 1) Analyzing adverse events and close calls

OVERVIEW OF THE SESSION

A process for analyzing adverse events that is systematic and system-focused is important for identifying system deficiencies and opportunities for improvement. This session will provide an overview of the safety analysis process. Guiding principles and the key steps in the safety analysis process will be discussed.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Explain how analyzing adverse events fits within the safety management cycle
- Identify the key steps in conducting a safety analysis
- Name legislation that governs quality assurance activities within Alberta

Patient Safety & Quality – Project

Lead – M Hofmeister

LEARNING TOPICS

- 1) Structuring and writing a project report

OVERVIEW OF THE SESSION

Successful completion of the course requires an effective presentation (oral and poster) of the student's project. This session will briefly review rhetorical communications theory and its application as well as pragmatic strategies for organizing the information that is to be communicated.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Develop an effective oral and written presentation of their project

FEBRUARY 7, 2012 (Tuesday 6-9:30pm)**Responding when healthcare delivery and outcomes are not optimal (II)**

Leads – B MacLeod, G McRae

LEARNING TOPICS

- 1) Immediate management
- 2) Supporting patients and healthcare providers
- 3) Reporting
- 4) Informing

OVERVIEW OF THE SESSION

When an adverse event occurs, the healthcare provider(s) and the organization responsible for providing care to patients have an obligation to effectively manage the situation. The first of a two part session will review an effective way to manage the important aspects immediately (first few hours) after the event as well as the

SESSION DETAILS

need to provide support to the patient and his / her family and the involved healthcare providers. The session will also provide an overview of the role of: 1) reporting and reporting systems; and 2) communicating information about the event to key stakeholders, an activity called informing.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Describe immediate actions to be considered when healthcare delivery and outcomes are not optimal resulting in patient harm
- Define reporting and informing and describe how they factor into a comprehensive approach for responding to an adverse event
- Apply the learning from this session (using tools and resources provided) in their own clinical or administrative environments

FEBRUARY 21, 2012 (Tuesday 6-9:30pm)

Responding when healthcare delivery and outcomes are not optimal (III)

Leads – B MacLeod, G McRae

LEARNING TOPICS

- 1) Disclosure

OVERVIEW OF THE SESSION

When an adverse event occurs, the healthcare provider(s) and the organization responsible for providing care to patients have an obligation to effectively manage the situation. This second of a two part session will review the important activity of disclosing information to the patient and his / her family / supporters about the adverse event.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Articulate the risks and benefits of providing patients and/or families with the most accurate understanding possible about what has happened with respect to their care
- Perform the core components of a disclosure conversation

MARCH 6, 2012 (Tuesday 6-9:30pm)

Leadership

Lead – D White

LEARNING TOPICS

- 1) Individual and team leadership
- 2) Organizational leadership

OVERVIEW OF THE SESSION

Leadership has emerged as a key theme in the rapidly growing movement to improve patient safety – leadership that is not confined to the board room and senior leadership but also is inclusive of leaders in clinical and non clinical environments.

In this session the participants will be engaged in discussion about the skills, knowledge and attributes leaders need to create and lead an organization focused on providing safer care. The session will review: 1) the important skill set of leaders; 2) the role of leaders at each level of an organization in creating a learning organization in which leaders integrate a safety vision and systems thinking around quality and safety throughout the organization; 3) the linkage between organizational culture, climate and patient safety; and 4) the impact of leadership on performance.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Describe the challenges faced by leaders in stewarding a quality and safety agenda
- Identify concrete ideas about what leadership can / should do to create successful structures and processes to enhance quality and safety

Patient Safety & Quality – Project

Leads – M Harvie, W Flemons

LEARNING TOPICS

- 1) Preparing for presentation day

OVERVIEW OF THE SESSION

The final day of the course (March 13) will consist of a series of 4 minute ‘rapid-fire’ oral presentations followed by time for poster presentations. In order for the oral presentations to flow smoothly, this session will briefly review the ‘rules’ and provide advice on how to structure this unique presentation format.

LEARNING OBJECTIVES

Upon completion of this session participants will be able to:

- Prepare an effective, brief oral presentation that covers the main issue, findings and recommendations that resulted from the project they worked on during the course

OVERVIEW OF PROJECT COMPONENT

Patient Safety & Quality – Project

Lead – W Flemons

OVERVIEW OF THE PROJECT COMPONENT

The project component of this course will provide participants the opportunity to practically apply knowledge gained from one or more of the topics that are taught in this course into work practice and/or the real world context. Projects can be done individually or in small groups of 2 or 3 people. Mentors will be available to help participants structure the project and provide advice. There will be dedicated time during each biweekly session to learn about how to complete a project, discuss your projects with other participants, and plan for the final presentation of your work. Participants are expected to complete and submit a project report as well as make a presentation to the other course participants (and faculty) about their project (scheduled for March 13, 8:30am-4pm).

For this course there will be a wide range of acceptable project types; participants are encouraged to choose topics that follow a typical improvement cycle for patient safety or quality issues: identify an opportunity for improvement (in safety language this would be a hazard / hazardous situation) → verify (justify) the observation through an analysis of it → establish a plan to improve → test the implementation of the plan (determine a method for measuring / evaluating) → measure / evaluate the implementation → draw conclusions about whether the change achieved the intended improvement → plan further improvements. Participants may choose to complete an entire cycle of improvement for a particular chosen issue or instead may choose to focus on one or two parts of the improvement cycle in depth. Although there will be some time during each structured session for participants to work on their projects, much of the project work will need to be completed outside of these sessions; a conservative estimate of the time commitment would be 30 to 40 hours.

LEARNING OBJECTIVES

Upon completion of the project the participant will be able to:

- Demonstrate application of knowledge related to patient safety and/or quality concepts in relation to work practice or a real world context

EXAMPLES OF PROJECTS *

- Identify an opportunity for improvement (or a hazard / hazardous situation) and analyze it through direct observation / data analysis / research literature synthesis → make and justify recommendations for improvement and a plan for how to test the recommendations
- Complete a detailed process map with an appropriate analysis to identify steps that can be improved → make and justify recommendations for improvement and a plan for how to test the recommendations
- Plan and complete one or more tests of change using one of the process improvement methods that are reviewed in the course (Plan / Do / Study / Act; Lean Six Sigma)
- Complete a heuristic evaluation of some type of equipment / technology used in healthcare → make and justify recommendations for improvement
- Complete an analysis of an adverse event or close call → make and justify recommendations to improve patient safety
- Analyze an administrative data set to identify an opportunity for improvement → justify the analysis and plan the next step to improve the situation
- Complete a review of safety learning reports that would identify one or more safety themes that suggest a system weakness in the delivery of care → complete an evaluation of the issue and make recommendations for improvement
- Engage patients / families to determine issues of importance from this perspective → complete an analysis that would validate the observations → justify a plan to improve the situation
- Complete an analysis of team or organizational leadership that contributes to an appropriate culture of safety and quality improvement
- Complete a detailed synthesis of the literature on a particular patient safety or quality topic → justify the relevance of the issue to a local context
- Developing a teaching session / toolkit for a patient safety or quality topic

* *Some projects may need review by an ethics board which may add complexity and extend project timelines. If a participant is considering such a project, they are encouraged to discuss this with the lead for the project part of the course prior to the course start date to discuss further.*

PROGRAM MAY CHANGE DUE TO CIRCUMSTANCES BEYOND OUR CONTROL

FACULTY

Dave Brewin PEng MHS c MBA(c)
Executive Director – TIP2 Access to Services & Clinical Transformation Services – Information Technology, Alberta Health Services

Dave has held several positions leading transformation and Quality Improvement in his decade-long healthcare career. Before joining Alberta Health Services (AHS), Dave was a Lean, Six Sigma consultant leading quality improvement projects in healthcare facilities across North America. He is currently engaged in the AHS Access to Services portfolio with a direct linkage to the strategic implementation of clinical information systems to improve quality and access to care provincially.

Jeff Caird PhD
Professor of Psychology, Faculty of Arts & Adjunct Professor, Departments of Kinesiology and Anesthesia, University of Calgary

Jeff is the Director of the Cognitive Ergonomics Research Laboratory and the Healthcare Human Factors and Simulation Laboratory. He has co-edited a number of books on human-machine systems, including the forthcoming Handbook of Driving Simulation in Engineering, Psychology and Medicine. His healthcare research includes human factors usability studies of equipment and environmental issues.

Jan Davies MSc MD FRCPC
Professor of Anesthesia and Adjunct Professor of Psychology, University of Calgary

Jan has worked and undertaken research in system safety over the past 25 years in healthcare and industry. She has been a consultant to various Canadian provincial medical examiners and coroners, Health Canada, and the Canadian Patient Safety Institute and is a co-author of the Canadian Patient Safety Dictionary. Her research areas include reactive and proactive methods of investigation at the system and individual levels.

Carmella Duchscherer RRT MPA
Administrative Director, W21C, University of Calgary

Carmella originally trained and worked as a Respiratory Therapist before moving into the fields of Quality Improvement and Patient Safety. Her primary interests are in systems safety and in conducting both prospective and retrospective system level safety reviews. Carmella has done a number of safety reviews, including large-scale multi-patient reviews, as well as teaches and mentors others on how to conduct safety reviews.

Ward Flemons MD FRCPC
Professor of Medicine, University of Calgary

Ward was VP of Quality, Safety & Health Information in the former Calgary Health Region for four years. He is a member of the Board of Directors of the Canadian Patient Safety Institute and is a medical advisor to the Health Quality Council of Alberta (HQCA). He is the Patient Safety Education lead for the Medical Ward of the 21st Century (W21C) Research & Innovation Centre at the University of Calgary, and co-lead of the HQCA's Blueprint Project for patient safety education in Alberta.

Bill Ghali MD MPH FRCPC
Professor of Medicine and Community Health Sciences, University of Calgary

Bill is Director of the Calgary Institute for Population & Public Health. He holds a Government of Canada Research Chair in Health Services Research and the Buchanan Chair in General Internal Medicine. Bill's research interests include cardiovascular and cerebrovascular disease, with a strong emphasis on Outcomes. He is a co-founder of the Medical Ward of the 21st Century (W21C).

Alexandra Harrison PhD
Adjunct Associate Professor of Community Health Sciences, University of Calgary

Alex's PhD research highlighted the critical role of patients and families in the coordination of health services. She has held leadership roles in Medical Education with the Canadian Medical Association and the University of Calgary and was the Director, Patient Experience with the former Calgary Health Region. She now teaches a graduate course for the Faculty of Medicine on 'Leadership in Health Care Organizations'.

Margot Harvie RN BN MEd
Director, Quality / Safety Education, Alberta Health Services

Margot has worked in various positions related to quality and patient safety since 1992 and has focused on quality and patient safety education for the past three years. She played an instrumental role in developing and implementing the educational initiatives for the roll-out of the Patient Safety policies in the former Calgary Health Region. She is a member of the core development team for the Health Quality Council of Alberta's Blueprint Project for patient safety education in Alberta.

Marianna Hofmeister MA PhD
Manager of the Physician Learning Program, University of Calgary

Marianna's career in healthcare started out at the west coast in Medical Laboratory Technology and continued through communications studies and medical education at the University of Calgary. She provides an enlightening, and at times, humorous perspective on how to create effective presentations.

Jayna Holroyd-Leduc MD FRCPC
Assistant Professor of Medicine and Community Health Sciences, University of Calgary

Jayna completed a research fellowship in geriatrics and quality improvement at the San Francisco VA Medical Centre and the University of California. Her research interests include knowledge translation, clinical decision support and improving care provided to older patients in hospital. She is the Clinical Informatics physician representative for Medicine within Alberta Health Services – Calgary and Area. She is also a member of the Alberta Clinicians Council, a provincial group that focuses on improving the care provided to Albertans.

FACULTY

Bruce MacLeod MD FRCPC

Medical Director, Patient Safety Alberta Health Services (South)

Bruce is a specialist in Emergency Medicine and for over a decade led the Calgary Health Region's Critical Incident Review Committee. For several years he was the Medical Lead for Clinical Safety Evaluation, before being appointed to his current role with Alberta Health Services. He led the roll-out of disclosure training in the Calgary area and is a certified Master Disclosure trainer through the Institute for Healthcare Communication.

Glenn McRae BSc BN RN MBA

Executive Director of Administrative Services with Emergency Medical Services (EMS) for Alberta Health Services

Glenn has a background in Critical Care and Emergency Nursing nationally (in the Canadian Forces) and internationally. Over the past nine years he has held several leadership positions in quality and patient safety. He completed the Advanced Training Program in Health Care Delivery Improvement through Intermountain Health Care, is a certified Master Disclosure trainer through the Institute for Healthcare Communication, and is also a surveyor with Accreditation Canada.

David Musson MD PhD

Director, Centre for Simulation-Based Learning;
Assistant Professor, Department of Anesthesia, McMaster University

David is the Director of the Centre for Simulation-Based Learning at McMaster University in Hamilton, Ontario, Canada. His teaching and research interests include the development of crew resource management (CRM) and team training programs for healthcare, and the use of simulation to train and assess multidisciplinary care teams.

Maeve O'Beirne PhD MD CCFP FCFP

Associate Professor of Family Medicine and
Community Health Sciences, University of Calgary

Maeve is a Family Physician and practices at the Low Risk Maternity Clinic and at an Academic Teaching Clinic in Calgary. Her research focuses on developing, implementing and evaluating strategies to improve patient safety in community-based settings. She is the co-chair of the Rural and Community Safety Committee for Alberta Health Services – Calgary Zone and sits on several Canadian Patient Safety Institute committees related to primary care.

Tom Ricento PhD

Professor and Chair, English as an Additional Language,
University of Calgary

Tom holds the first North American Chair in English as an Additional Language. He specializes in language policy and has investigated the roles played by language and culture in access to and delivery of health care services in the US and Canada. He was PI in a research project funded by the Russell Sage Foundation (New York) that looked at patterns of language use and communication in a Hispanic-serving medical clinic in San Antonio, TX. In Canada, he is PI in a project investigating linguistic and cultural barriers to the successful integration of government-sponsored refugees in Calgary. His PhD is from UCLA (Applied Linguistics) and he has more than 50 publications in the areas of language policy, sociolinguistics, and health literacy.

Tom Stelfox MD PhD FRCPC

Assistant Professor of Critical Care Medicine, Medicine, and
Community Health Sciences, University of Calgary

Tom practices as an Intensive Care specialist. He completed his PhD in Health Care Policy at Harvard University and a Critical Care Fellowship at the Massachusetts General Hospital. His research program focuses on the application of health services research methods to evaluate and improve the quality of healthcare delivery to critically ill patients.

Debbie White RN PhD

Associate Professor, Faculty of Nursing, University of Calgary

Debbie is the Associate Dean of Research for the Faculty of Nursing. Her research program in Patient Safety and Quality of Care focuses on the impact of organizational practices and structures and processes in the work and learning environments on patient, provider and system outcomes. She currently leads a national study on the value and impact of quality and safety teams in Canadian hospitals.

Dale Wright BSP MSc MDE

Quality & Safety Initiative Lead, Health Quality Council of Alberta

As Quality & Safety Initiatives Lead with the Health Quality Council of Alberta, Dale has managed several province-wide initiatives to improve health service quality and safety. She is Co-Chair of the Blueprint for Patient Safety Education Project with Ward Flemons. Since 2009 she has delivered numerous workshops on integrating ethics into quality and safety projects through the ARECCI Project Ethics initiative.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

In keeping with accreditation guidelines, speakers participating in this event have been asked to disclose to the audience any involvement with industry or other organizations that may potentially influence the presentation of the educational material. Disclosure may be done verbally or using a slide prior to the speaker's presentation.

GENERAL INFORMATION

CONFIRMATION OF REGISTRATION

Registration confirmation will be in the form of a tax receipt. No other confirmation will be sent. Please allow 2 weeks for registration processing.

REFUND POLICY

A registration refund will be made upon written request prior to September 2, 2011. However \$45 will be retained for administrative costs. Refunds after that date will be at the discretion of the Office of Continuing Medical Education and Professional Development. NOTE: Refunds are processed only on the return of original receipt. All receipts must be returned within 30 days after program date.

COURSE CANCELLATION POLICY

The Office of Continuing Medical Education and Professional Development reserves the right to cancel the course if there are insufficient registrations.

REIMBURSEMENT OF REGISTRATION FEES

Physicians may be eligible for reimbursement of registration fees and expenses to attend CME courses from a fund administered by the Alberta Medical Association. For more information regarding this, please call the AMA at (780) 482 2626 or 1 800 272 9680.

ACCREDITATION

The University of Calgary – Office of Continuing Medical Education and Professional Development is fully accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS).

STUDY CREDITS

This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for up to 44 MAINPRO-M1 credits.

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification program of Physicians and Surgeons of Canada. This program has been reviewed and co-sponsored by Continuing Medical Education and Professional Development, University of Calgary.

This course will offer up to 44 non-accredited CEUs for Pharmacists that can be used towards a personal portfolio with the Alberta College of Pharmacists.

Attendance at this program entitles certified Canadian College of Health Service Executives members (CHE / Fellow) to 22 Category II credits toward their maintenance of certification requirement.

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

Registration information is collected under the authority of the *Freedom of Information and Protection of Privacy Act*. The contact information you provide is required by our Office to register you in the course, prepare material for your use and notify you of upcoming courses offered by our Office. Financial information is used to process applicable fees and is retained for future reference. If you have questions about the collection or use of this information, call the Research Associate at the Office of Continuing Medical Education and Professional Development (403) 220 4268.

FOR FURTHER INFORMATION

Office of Continuing Medical Education and Professional Development, Faculty of Medicine, University of Calgary, TRW Building, 3280 Hospital Drive NW, Calgary, AB T2N 4Z6

Course Information

Cortney Snell
Phone (403) 220 8067
Fax (403) 270 2330
Email csnell@ucalgary.ca

Course Registration

Phone (403) 220 7032
Email cmereg@ucalgary.ca

VISIT OUR WEBSITE

www.cme.ucalgary.ca

REGISTRATION FORM

CERTIFICATE IN PATIENT SAFETY & QUALITY
Fall 2011 / Winter 2012

PROFESSION	SPECIALIST PHYSICIAN	PHYSICIAN	NURSE	PHARMACIST	OTHER (SPECIFY)	PLANNING COMMITTEE/ FACULTY
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FIRST NAME						
<input type="text"/>						
LAST NAME						
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ADDRESS						
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CITY					PROV	POSTAL CODE
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AREA CODE	PHONE		AREA CODE		FAX	
<input type="text"/>	<input type="text"/> - <input type="text"/>		<input type="text"/>		<input type="text"/> - <input type="text"/>	
EMAIL						
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PAYMENT BY	CHEQ	AMEX	VISA	MASTERCARD	CARD NUMBER	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	
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Check here if you would like the above email address used to receive our monthly CME newsletter with course updates

REGISTRATION FEE

Includes dinner, nutrition breaks, handout materials
PLEASE NOTE: dinners will include a vegetarian selection; we are unable to accommodate special dietary restrictions (for example, gluten free, peanut allergies).

- \$2250 Physicians & Health Care Professionals
 \$500 Students / Residents

See "GENERAL INFORMATION" for
"Freedom of Information and Protection of Privacy Act"

REGISTRATION INFORMATION

Phone (403) 220 7032, Email cmereg@ucalgary.ca

REGISTER BY MAIL

Mail Registration Form with payment to
Office of Continuing Medical Education and Professional
Development, Faculty of Medicine, University of Calgary,
TRW Building, 3280 Hospital Drive NW, Calgary, AB T2N 4Z6
Cheque payable to UNIVERSITY OF CALGARY

REGISTER BY FAX

Registration with credit card payment may be faxed to
(403) 270 2330

REGISTRATION DEADLINE

September 6, 2011

REGISTRATION LIMITED TO 30 PARTICIPANTS