CERTIFICATE IN PATIENT SAFETY & QUALITY

FALL 2010
September 21-December 14
WINTER 2011
January 11-February 22

PRESENTATION DAY
March 1, 2011

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
3330 Hospital Drive NW
Calgary, AB

REGISTRATION LIMITED TO 30 PARTICIPANTS

Blueprint Project
Transforming Patient Safety Education in Alberta
A collaborative sponsored by the HQCA

W21C Medical Ward of the 21st Century

UNIVERSITY OF CALGARY
MEDICINE

Office of Continuing Medical Education and Professional Development

Creating the future of health

COURSE DETAILS

- The course will take place biweekly on Tuesday evenings, 6-10pm (starting September 21, 2010); dinner will be served starting at 5:30pm
- 11 sessions plus a single all-day session for presentations
- Participants will be expected to complete a project and mentors will be available to assist
- Participants will be eligible for continuing education credits (College of Family Physicians / Royal College / College of Pharmacy / College of Health Service Executives)

COURSE REQUIREMENTS

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

- Participation during the eleven biweekly modules (minimum of 8 sessions must be attended)
- Completion of a 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 & 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

MODULE OUTLINE

SEPTEMBER 21, 2010
Patient Safety & Quality – Background
- History
- Epidemiology
- Models
- Principles

W Flemons

OCTOBER 5, 2010
Designing healthcare for optimal outcomes (I)
- Human factors
- Understanding success & failure in healthcare

J Davies, J Caird

OCTOBER 19, 2010
Designing healthcare for optimal outcomes (II)
- Identifying opportunities to improve
- Prioritizing opportunities
- Ethical issues

J Holroyd, T Stelfox, M O'Beirne

NOVEMBER 2, 2010
Designing healthcare for optimal outcomes (III)
- Outcome measurement
- Evaluative / QI design

J Holroyd, T Stelfox, M O'Beirne

NOVEMBER 16, 2010
Designing healthcare for optimal outcomes (IV)
- Clinical informatics
- Using evidence-informed decision making

J Holroyd, T Stelfox, M O'Beirne

NOVEMBER 30, 2010
Application of quality and patient safety tools
- Lean / Six sigma
- Analyzing adverse events

D Brewin, C Duchscherer

DECEMBER 14, 2010
Delivering optimal care (I)
- Patient engagement

A Harrison

JANUARY 11, 2011
Delivering optimal care (II)
- Communication
- Teamwork / Crew resource management

J Davies

JANUARY 25, 2011
Respond when healthcare delivery and outcomes are not optimal (I)
- Immediate management
- Supporting patients & providers
- Reporting
- Informing

B MacLeod, G McRae

FEBRUARY 8, 2011
Respond when healthcare delivery and outcomes are not optimal (II)
- Disclosure
- Evaluation of individuals vs evaluation of systems

B MacLeod, G McRae

FEBRUARY 22, 2011
Leadership
- Individual and team leadership
- Organizational leadership

T Kline, D White

PRESENTATION DAY

MARCH 1, 2011

SEPTEMBER 21, 2010 (Tuesday 6-8:45pm)

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

OCTOBER 5, 2010 (Tuesday 6-8:45pm)

Designing healthcare delivery for optimal outcomes (I)

Leads – J Caird, J Davies

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 central role has grown, with the introduction of the specialty of Human Factors to healthcare and patient safety. There are almost as many Human Factors (HF) publications cited in Medline for 2003 now as there were for 1902-2002 and nearly five times the number of articles about both Human Factors and patient safety. However, despite the interest in Human Factors, there are suggestions that the extent of knowledge and skills pertaining to the specialty of Human Factors is not completely appreciated. For example, HF covers more than the topics of 'fatigue' or 'team work'. Allied with the topic of Human Factors 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 the participant will be able to:

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

OCTOBER 19, 2010 (Tuesday 6-8:45pm)

Designing healthcare delivery for optimal outcomes (II)

Leads – J Holroyd, T Stelfox, M O'Beirne

LEARNING TOPICS

1) Identifying opportunities to improve; 2) Prioritizing opportunities; 3) Ethical issues

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. Moving on, the session will then look at: 1) how to develop an appropriate question (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.

The second part of this session will explore the ethical issues created by the desire to improve a system of care delivery. Guidelines for when and how to seek approval from ethic review boards for a proposed intervention will be covered as well as looking at when consent is required / advisable. Finally, the issue of de-identifying data that is collected will be reviewed.

Prior to the start of this session a questionnaire will be used to assess the baseline participant knowledge of the concepts that will be taught in this session and the following two sessions on designing healthcare delivery.

LEARNING OBJECTIVES

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

- Develop an approach to designing Safety / QI interventions
- Describe the role of ethics and consent in Safety / QI interventions

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NOVEMBER 2, 2010 (Tuesday 6-8:45pm)

Designing healthcare delivery for optimal outcomes (III)

Leads – J Holroyd, T Stelfox, M O'Beirne

LEARNING TOPICS

1) Outcome measurement; 2) Evaluative / QI design

OVERVIEW OF THE SESSION

One of the greatest challenges in the successful implementation of an improvement project is to know if the changes have actually made a difference. This issue will be explored through a discussion of outcome measurement as viewed through the lens of the 'clinical value compass' and a review of potential data sources (medical record; administrative data; patient safety learning reports; etc) with an awareness of their strengths and limitations. The discussion of quantitative methods for gaining understanding will be complemented with a discussion about qualitative methods that can be used in safety and QI projects

The session will also introduce some of the unique methods for testing and introducing interventions (focusing on PDSA – Plan / Do / Study / Act) and looking at experimental and quasi-experimental designs in safety / QI projects.

LEARNING OBJECTIVES

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

- Identify outcome measures relevant to Safety / QI work
- Develop an understanding of designs that can be used in Safety / QI

NOVEMBER 16, 2010 (Tuesday 6-8:45pm)

Designing healthcare delivery for optimal outcomes (IV)

Leads – J Holroyd, T Stelfox, M O'Beirne

LEARNING TOPICS

1) Use of evidence-informed decision making ;
2) Clinical informatics / Clinical decision support

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 (making your own). The session will also review the use of knowledge translation strategies (integrated 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.

Following the end of this session, a questionnaire will be used to assess participants' knowledge acquisition of the concepts that were covered in the previous three sessions of designing healthcare delivery (II-IV).

LEARNING OBJECTIVES

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

- Learn how to incorporate best evidence into Safety / QI interventions
- Describe the role of electronic data in Safety / QI projects

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NOVEMBER 30, 2010 (Tuesday 6-8:45pm)

Application of quality and patient safety tools

Leads – D Brewin, C Duchscherer

LEARNING TOPICS

1) Lean / Six sigma; 2) Analyzing adverse events & close calls

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 teach participants practical tools for Analyzing Adverse Events for identifying system deficiencies and Lean Six Sigma tools for improving process/quality.

- 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.

• 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.

LEARNING OBJECTIVES

Upon completion of this session the participant 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
- Identify the key steps in conducting a safety analysis
- Name legislation that governs quality assurance activities within Alberta

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DECEMBER 14, 2010 (Tuesday 6-8:45pm)

Deliver 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 the participant 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

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JANUARY 11, 2011 (Tuesday 6-8:45pm)

Deliver optimal care (II)

Lead – J Davies

Co-presenters JN Armstrong, A Mayer

Learning Topics

1) Communication; 2) Teamwork / Crew resource management

OVERVIEW OF THE SESSION

Every one of us communicates but 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.

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

LEARNING OBJECTIVES

Upon completion of this session the participant 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 SBAR
- Outline the basics of working groups and team formation, maintenance and function

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JANUARY 25, 2011 (Tuesday 6-8:45pm)

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

Leads – G McRae, B MacLeod

LEARNING TOPICS

1) Immediate Management; 2) Supporting patients & 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 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 the participant will be able to:

- Compare and contrast the roles and challenges leaders at different levels of a healthcare organization face in ensuring the delivery of safe, high quality care
- Describe the key attributes of effective leaders managing front-line teams to deliver safe healthcare
- Explain how non-technical skills of healthcare teams are a critical component for delivering safe and effective care
- Define 'safety culture', describe its importance in patient safety, and critique methods of measuring it
- Debate what is required to build and sustain a healthcare safety culture

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FEBRUARY 8, 2011 (Tuesday 6-8:45pm)

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

Leads – G McRae, B MacLeod

LEARNING TOPICS

1) Disclosure; 2) Evaluation of individuals vs evaluating systems

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: 1) the important activity of disclosing information to the patient and his / her family / supporters about the adverse event; and 2) a procedure (including the use of decision algorithms) for evaluating the actions, decisions and behaviours of individual providers in contrast to evaluating system factors. A discussion of the just and trusting culture principle as it applies to the evaluation of individuals will take place during this session.

LEARNING OBJECTIVES

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

- Describe commonly debated elements involved in the determination of whether to review the individual, the system or both when healthcare delivery and outcomes are not optimal resulting in patient harm
- Explain how a Just & Trusting culture of safety differs from routinely held community and professional beliefs and expectations
- 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

FEBRUARY 22, 2011 (Tuesday 6-8:45pm)

Leadership

Leads – T Kline, D White

LEARNING TOPICS

1) Individual & 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 the participant 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

OVERVIEW OF PROJECT COMPONENT

SEPTEMBER 21, 2010 – MARCH 1, 2011

Patient Safety & Quality Projects

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 1, 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.*

FACULTY

Dave Brewin PEng MHSc
Lead, Transformation Support 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 strategy for and deployment of the provincial Electronic Health Record for AHS, focusing on Benefits Realization, Organizational Change Management, eLearning and Business Analysis.

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.

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.

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

Theresa Kline PhD
Professor of Psychology, Faculty of Arts, University of Calgary

Theresa has an active research program in the area of team performance. Her other research interests include psychometrics, organizational effectiveness, and work attitudes. She has published two books on teams, Teams that Lead (2003) and Remaking Teams (1999), and one on psychometrics, Psychological Testing (2005), and has written more than 70 peer-reviewed articles.

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 Patient Safety, 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.

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 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.

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

On-line registration confirmation is automatic after registering on-line. A tax receipt will be sent approximately 2 weeks after registering.

For all other methods of registration (mail, fax) 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 13, 2010. 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 44 CEU credits for Pharmacists as determined by the Alberta College of Pharmacists – Course Number: AB10-027.

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

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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 2010 / Winter 2011

PROFESSION ☐ SPECIALIST PHYSICIAN ☐ PHYSICIAN ☐ NURSE ☐ PHARMACIST ☐ OTHER (SPECIFY) _____

FIRST NAME _____

LAST NAME _____

ADDRESS _____

CITY _____ **PROV** _____ **POSTAL CODE** _____

AREA CODE _____ **PHONE** _____ – _____ **AREA CODE** _____ **FAX** _____ – _____

EMAIL _____

PAYMENT BY ☐ CHEQ ☐ AMEX ☐ VISA ☐ MASTERCARD **CARD NUMBER** _____

EXPIRY M M _____ / Y Y _____ **SIGNATURE** _____

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

☐ **$1500** **Physicians & Health Care Profesionals**
☐ **$500** **Students / Residents**

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

REGISTRATION INFORMATION

Phone (403) 220 7032, E-mail cmereg@ucalgary.ca

REGISTER ON-LINE

https://cmeregistration.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, 2010

REGISTRATION LIMITED TO 30 PARTICIPANTS