



13th Northwest Patient Safety Conference
May 13, 2015
Lynnwood Convention Center, Lynnwood, WA
7:30 a.m. – 4:00 p.m.

Keynote speaker Ronald Wyatt, MD, MHA is the Medical Director in the Division of Healthcare Improvement at The Joint Commission. He promotes quality improvement and patient safety to internal and external audiences, works to influence public policy and legislation for patient safety improvements, and serves as the lead patient safety information and education resource within The Joint Commission. Dr. Wyatt collaborates in the development of National Patient Safety Goals, and oversees data management and analyses related to the Sentinel Event database. Dr. Wyatt actively presents on a variety of patient safety topics throughout the US and Canada. He has written and published numerous articles on patient safety topics.

Morning concurrent sessions

How to involve patients and the public in guideline development: the G-I-N PUBLIC toolkit (Kaiser Permanente Northwest)

Incorporating patient and consumer involvement in clinical practice guideline (CPG) activities has become a priority for health care organizations internationally. In diverse populations with potential healthcare disparities, the development of culturally competent patient tools based on interpretation of preexisting clinical practice guidelines is also considered important practice for many organizations that adopt external guidelines. This work addresses challenges organizations face in utilizing consumers/patients in developing clinical practice guideline (CPG) patient-support tools for preventive care. The speaker will discuss consumer recruitment, topic identification, structured curriculum, culturally relevant tool development, implementation, and follow-up.

In Room 1B/C at 9:45.

Root cause analysis: lessons learned from highly reliable organizations (Life Flight Network)

Historically, healthcare has used what is known as 'blame and shame' during the initial and post investigation phase of medical error analysis. The opposite is true of Highly Reliable Organizations (HRO's) which focus on what went wrong and why, vs. who did something wrong. HRO's utilize A Just Culture theory to guide the Root Cause Analysis and how to address behavioral aspects of human error. This presentation will emphasize the importance of both error and near miss reporting, utilizing A Just Culture and Human Factors in error investigation. The reporting of near misses is paramount in the discovery of latent errors; a vitally important aspect of a culture of safety. Health care compared to HRO's have a low reporting rate of near misses, thereby missing opportunities to prevent errors from occurring. Using a Just Culture will create a psychological safety net, increase reporting of errors and near misses, and ultimately improve patient safety.

In Room 1D at 9:45.

Equipping physicians to reduce low-value care (Group Health and Northwest Physicians Network)

A national initiative of the American Board of Internal Medicine (ABIM) Foundation, Choosing Wisely has enlisted more than 60 medical specialty societies to create lists of "Things Physicians and Patients Should Question" which provide specific evidence-based recommendations for conversations on the risks and benefits of various medical tests. Choosing Wisely aims to promote conversations between physicians and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm and truly necessary. The Washington State Choosing Wisely Task Force recently published the first statewide study in the nation to measure Choosing Wisely recommendations. The study, based upon claims data representing 3.3 million lives in Washington state, finds that patients in Washington are exposed to care that they don't need—and potential

harm. To support physicians seeking to integrate Choosing Wisely recommendations into their practices, the task force also developed an action manual that outlines eight steps for leading change that include developing a change vision and generating short-term wins.

In Room 1E at 9:45.

How do we support the Second Victim? (multi-organization panel)

A “Second Victim” is a provider involved in an error, unanticipated event, or patient injury and who is traumatized by the event. The effects of trauma may last for years, and in the short- and long-term affect many aspects of the provider’s life. After a brief introduction and overview the panel will present several examples of Second Victim support programs in the Northwest, with time for discussion of the challenges and opportunities presented in supporting our healthcare individuals and teams during and following unanticipated outcomes. Attendees will learn to assess existing resources within their organization in order to develop effective programs.

In Room 1F at 9:45.

Honoring Choices Pacific Northwest Initiative (Virginia Mason Medical Center and the Washington State Medical Association)

Honoring Choices Pacific Northwest, a joint initiative of the Washington State Hospital Association (WSHA) and the Washington State Medical Association (WSMA), encourages early conversations about the type of care people would want if faced with a life threatening illness. It does this in two major ways. One, the program provides training and resources to hospitals and physicians to make sure they are prepared to discuss, record and honor people’s wishes at the end of their life. Second, a public website offers individuals and families a place to learn about their choices and encourages conversations about their wishes ahead of time. This presentation will describe why end of life care planning is so important and will outline how Honoring Choices PNW plans to improve end of life care in Washington State.

In Room 1 B/C at 10:50.

Designing the “magic pill” for medication reconciliation (Veterans Administration Portland Health Care System)

Medication discrepancies at interfaces-in-care are an important source of preventable iatrogenic injury, causing an estimated 1 million hospitalizations and 7,000 deaths in the US annually. While medication reconciliation (MR) has been described as an effective process to surface medication discrepancies and avoid adverse drug events, most institutions have struggled to implement durable MR interventions. The Veterans Health Administration (VHA) features a robust electronic health record and manages the entire medication distribution supply chain from provider order entry to home medication delivery. The speaker will discuss ambulatory patient-centered care using a multimedia module on a self-service kiosk that allows patients to input information on how they take their medications, and the inpatient mobile MR application to improve patient self-efficacy and clinician accuracy.

In Room 1D at 10:50.

Reducing adverse drug events across the care continuum (Qualis Health)

Adverse drug events cause a substantial burden to our health care system, accounting for over 100,000 emergency hospitalizations each year, with many more events occurring in the community setting. In this presentation we will discuss the scope of this problem, the known risks for adverse drug events, and the application of best practices to reduce harm and improve safety of our patients.

Through the application of best practices and the focus in patient-centered care and collaboration, we will share how local and national health care teams have improved patient outcomes and reduced adverse drug events in high risk patient populations.

In Room 1E at 10:50.

Buyer Beware: How far can you trust health choices information broadcast to the public? (Applied Epidemiology)

The television and internet bring popular advice and comparative information directly to the public, with an intention of influencing their health care decisions. Does that information portray healthcare providers fairly? Do they find it useful, or untrustworthy, as part of informed consent discussions with their patients? How much solid evidence is there behind what those popular television doctors advise? This session will review the concept of evidence in evidence-based medical care, and how to evaluate its credibility. It also will review how generic quality assurance validation standards evolved, their successful application in healthcare-associated infection reporting by Washington

State, the national organizations that influence such reporting, and the actions that lay and professional individuals can take to have the most influence on key organizations.

In Room 1F at 10:45.

Morning workshop:

Team Strategies and Tools to Enhance Performance and Patient Safety: Make it Happen, Make it Stick (North Carolina Quality Center)

Workshop participants will complete a pre-work assessment sheet on patient safety strengths, weaknesses, opportunities and threats in their unit, clinic, or other work area, and will read a pre-work handout overview of key TeamSTEPPS (TS) tools. During the workshop, participants will receive a brief background overview of patient safety culture and the history and uses of TS, and an overview of the TS tools with a focus on five specific tools: Call Out, Checkback, SBAR, CUS and DESC. Interactive exercises and low fidelity simulations practicing these skills will be facilitated and debriefed, embedding the additional tools of briefing, huddles, and debriefing. Methods of using these tools to improve the patient-centeredness of care will be discussed. The session will be highly interactive— participants will share strategies and barriers with each other, will work in small groups to complete exercises, will engage in simulation of clinical and operational scenarios, and will discuss feedback on simulations and exercises.

Note: Attendance is limited to those who preregistered.

In Room 2 B/C at 9:45.

Qualis Health Awards of Excellence in Health Care Quality will be announced at lunch.

Plenary speaker Tiffany Christensen is the Performance Improvement Specialist at the North Carolina Quality Center and speaks from the perspective of a life-long patient and a professional patient advocate. She is a TeamSTEPPS Master Trainer, a Respecting Choices Advance Care Planning Instructor, an APPEAL certificate recipient, and the creator of her own Train the Trainer workshop series entitled “Finding Your Voice in the Healthcare Maze.” Christensen is a nationally recognized public speaker and the author of three books exploring advocacy, end of life planning and partnership strategies in healthcare. She is a board member of the Beryl Institute for improving the patient experience, and faculty for the Patient Safety Officer Training at the Institute for Healthcare Improvement in Cambridge, Massachusetts.

Best Poster Award will be announced.

High-Intensity Talks and discussions

In order to facilitate discussion, conference attendees will be assigned to tables with a diverse set of colleagues.

Novel approach to violence risk assessment in the healthcare setting (VA Puget Sound)

More than 10 percent of hospital employees report at least one work-place assault per year. Patients may also become victims of disruptive behavior in the healthcare setting, and are the most common assaulters. The VHA (Veterans Health Administration) has directed its hospitals to create a Disruptive Behavior Committee (DBC) to identify patients who pose elevated risk for violence at their facilities. This talk will provide an overview of the program and lessons learned from starting such a program.

Adverse events: how are we doing? (The Foundation for Health Care Quality)

Health care facilities in Washington State submit information about serious adverse events to a Department of Health database. What does that information tell us, and what next steps can we take to continue to improve safety?

Parent engagement in root cause analysis: one center’s experience of partnering with families in the process of root cause analysis (Seattle Children’s Hospital)

Healthcare organizations struggle with how much to involve patients and families in improvement work, particularly when the work involves highly confidential and sensitive information. This involvement in safety work after an adverse event has occurred can be even more daunting as it exposes some of the organization’s deepest flaws, potentially creating an uncomfortable situation for the organization. However, patients and families are not blind to those flaws and bring a perspective to events as crucial as any other discipline routinely invited to the discussion. Seattle Children’s Hospital has begun incorporating families in their root cause analysis work despite these roadblocks

and assumptions. The speaker will address the importance of having the patient and family discipline at the table, the unique challenges identified by both staff and family representatives, and share key learnings from qualitative interviews conducted after root cause analysis cases in which a family representative participated.

Afternoon workshop:

Operationalizing patient- and family-centered care (Duke University)

This 90-minute interactive workshop will address ways in which TeamSTEPPS tools and methods had be used with patients and families (e.g., SBAR for patients) and engaging patient and family advisory councils more effectively. It will be presented by plenary speaker Tiffany Christensen.

Note: attendance limited to those who pre-registered. Others may be admitted, space permitting.

In Room 2 B/C at 2:35.

All day:

- **Book sale** presented by University Bookstore, Health Sciences Branch
- **Exhibitors and sponsors**