Canadian Healthcare Association
Association canadienne des soins de santé

cpsi icsp Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

Canadian Patient Safety Officer Course 2012
Core Content Framework

February 21-24, 2012, Vancouver, BC
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The following core themes are the cornerstones around which the curriculum for the 2012 CPSO Course is being developed.

History of Patient Safety: Where are we now?
At the end of the session, the participants will be able to:

- Have an appreciation of the history of the patient safety movement;
- Understand the basic language and common terms used in patient safety;
- Understand the major findings from benchmark studies and the Canadian study; and
- Appreciate the relative contribution of the individual and the system to patient safety.

A-B-C's of Patient Safety: Bringing Your Program to Life
Frameworks to manage change and implement patient safety initiatives; Goal setting in developing a patient safety program; Models for improvement; Tools and techniques to develop your program. At the end of the session, the participants will be able to:

- Develop a personalized inventory of potential patient safety champions/advocates;
- Utilize a national framework to develop the patient safety program;
- Integrate change management theory to minimize resistance and maximize success of patient safety initiatives; and
- Incorporate an improvement model into your patient safety program.

Just Culture and Disclosure
Generative safety culture; Building a just culture; Organizational culture disclosure defined; Case-based disclosure. At the end of the session, the participants will be able to:

- Define the disclosure process;
- Synthesize the process of disclosure by case-based learning;
- Identify the challenges and benefits of the integration of the national disclosure guidelines; and
- Appreciate the value of generative culture to the success of patient safety initiatives.

Human Factors and Patient Safety
At the end of the session, the participants will be able to:

- Define human factors and describe key concepts;
- Examine the relationship between human factors and patient safety principles; and
- Understand how to apply human factors concepts in real-life situations in health care.

The Role of the Board in Patient Safety
At the end of the session, the participants will be able to:
- understand the role of the governing body for quality and safety;
- learn about some leading governance practices for quality and safety; and
- identify how management and staff can support the board in carrying out its governance role.

Patient Perspectives
At the end of the session, the participants will be able to:
- Understand the impact of an adverse event on the patient and family;
- Develop strategies to integrate patients into patient safety efforts; and
- Define the role of patient-based advocacy organizations in affecting system change.

Engaging Clinicians
Spreading patient safety throughout organizations; Defending the evidence for safety; Leadership across the healthcare professional spectrum. At the end of the session, the participants will be able to:
- Utilize effective tactics for engagement of clinicians;
- Discuss the concept of spread in safety; and
- Describe the evidence versus intuitive support for safety initiatives.

Resiliency and Reliability Science
At the end of the session, the participants will be able to:
- Define elements of a safety management system (SMS) taken from high risk industry;
- Recognize how the elements of resiliency contribute to safer care;
- Recognize the principles of reliability science;
- Appreciate the value of effective SMS as it relates to safety goals; and
- Assess the strengths and weaknesses of Patient safety programs as it relates to a safety management system.

Life Cycle of a Patient Safety Incident: Reporting, Disclosing, Learning and Informing
Understanding the continuum of communication of event analysis, including the role of the patient safety officer in reporting, disclosing, learning and informing following a patient safety incident. At the end of this session participants will be able to:
- Inform the patient, family, healthcare organization, media and the broader community after a patient safety incident, including the development of a crisis communication plan and the building of key messages for the specified target audience;
- Determine the contributing factors and root causes that led to a patient safety incident and provide strategies for developing effective recommendations and implementing actions for systems improvement; and
- Understand how a clear and consistent approach to disclosure and apology (when appropriate) related to harm and adverse events can support patients, families and healthcare providers to heal and rebuild trust.

Safety Culture Measurement and Improvement
At the end of the session, the participants will be able to:

- Understand the nature and importance of safety culture and its relationship with patient safety;
- Appreciate the strengths and weaknesses of instruments currently available to measure safety culture; and
- Develop a strategic plan for safety culture measurement and improvement.

Building a Strategy & Structure for Patient Safety
At the end of the session, the participants will be able to:

- Understand the spectrum of elements that encompass complete patient safety program;
- Construct a patient safety program template for your organization; and
- Embed measurement and evaluation techniques into your patient safety program.

Facilitated Workshop
The course concludes with a three-hour structured workshop that uses reflective analysis to help participants consolidate the course learning objectives into a personalized action plan.
At the end of the session, the participants will be able to:

- Identify key gaps in their organization's patient safety program; and
- Identify the top three post-course activities to be actioned.