

Primary Care Patient Safety Learning Collaborative

Webinar – May 24, 2017

Webinar session goals:

- Provide a forum for networking and sharing
- Support patient safety improvement projects
- Deliver learning content as requested

Learning Collaborative

(11 month time frame)

Topic:
**Primary
Care
Patient
Safety**

**Design
Meeting**

February 23/17

**Develop
Frameworks
& Elements**

Participants (teams representing 14 academic sites)

Pre-work

Action Period

Action Period

Action Period

LS 1

LS 2

LS 3

Congress

March 31/17

June 16/17

October 20/17

February 9/18

Support

Website

<http://www.dfc.utoronto.ca/patient-safety>

A list of the learning collaborative patient safety projects can be found [here](#).

A link to the Patient Safety Learning Collaborative (PSLC) Team Assessment can be found [here](#). [↗](#)

Learning Session Documents

[Learning Collaborative Session 1 - March 31, 2017](#)

Learning Collaborative Important Dates:

- March 31, 2017 - Learning Session 1
- June 16, 2017 - Learning Session 2
- October 20, 2017 - Learning Session 3
- February 9, 2018 - Congress

All sessions are from 8:00am to 12:00pm in room 365/303 at the DFCM (500 University Ave).

Learning collaborative Webinar Dates - from 12:00pm to 1:00pm:

- April 27, 2017
- May 24, 2017
- July 19, 2017
- August 16, 2017
- September 20, 2017
- November 22, 2017
- January 17, 2018

Adobe Connect link to join the webinar: <http://uoftfamilymedicine.adobeconnect.com/patientsafety-lc-webinar> [↗](#)

Dial in teleconference information:

Local: 416-933-3825

Toll free: 1-866-602-6731

Conference ID: 7564724

Patient Safety Resources

[Significant Event Analysis \(SEA\) Framework](#)

[Patient Safety References of Interest in Primary Care](#) (most helpful highlighted)

Articles/Publications

Projects to date

Patient Safety Learning Collaborative Projects

Below is a list of the Primary Care Patient Safety Learning Collaborative Projects:

- Reducing high-risk opioid prescribing starting with a focus on reducing opioid and benzo co-prescription - St. Michael's Hospital
- Development of a patient safety committee of multidisciplinary team members in the RVH Family Medicine Teaching Unit - Royal Victoria Hospital
- Choosing Wisely Canada and developing a Safety Learning System: setting the foundation and conducting one SEA (Significant Event Analysis) - Southlake Regional Health Centre
- Markham, Women's College and Toronto Western Family Medicine Teaching Units are collaborating in a review of Significant Event Analysis and its use in family medicine / primary care. We have agreed to make this a reflective piece and are searching for an evaluative model that might assist us. The evaluation will be mainly qualitative though having joined together, we are considering whether we have sufficient volume to add a quantitative component. Interest has been shown to include a few priority areas in this reflection, such as the effect of medico-legal concerns on Significant Event Analysis. This collaboration may be extended as we are examining opportunities to disseminate results through presentation and publication, given the scarcity of Canadian literature on patient safety in primary care - Markham, Women's College and Toronto Western Hospital

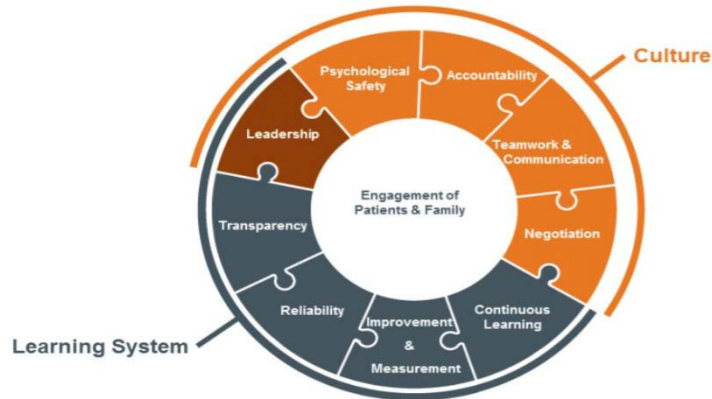
Updates

- QI coaching available beginning June 5th - Lorri Zagar & Christina Southey
- Learning Session 2 – June 16th (0800-1200)

Team Assessment

https://dfcmutorontoca.qualtrics.com/jfe/form/SV_eIPqwXa4MSazUZn

Figure 1. Framework for Safe, Reliable, and Effective Care



Make a commitment ... take action to address patient safety in meaningful ways
(**Accountability**) (**Leadership**)

Create a supportive culture ... advance patient safety learning and teaching without ascribing blame (**Psychological safety**) (**Negotiation**) (**Transparency**)

Engage patients ... seek to understand what safety means to them and the areas that they would like improved

Involve the team ... drive staff, faculty and trainees' engagement in patient safety
(**Teamwork and Communication**)

Measure performance ... implement mechanisms to track and monitor patient safety
(**Improvement and Measurement**) (**Reliability**)

Share experiences ... introduce vehicles to exchange patient safety ideas and learnings within and across sites (**Continuous learning**)

Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.

Networking...

QUESTIONS?

