Signature Event Report: Recommendations and Proceedings

Cancer Quality Council of Ontario
2014 Signature Event
November 19, 2014
DoubleTree by Hilton Hotel, Toronto

Cancer Quality Council of Ontario – membership as of November 19, 2014

The Cancer Quality Council of Ontario (CQCO) Council is a multidisciplinary group of healthcare providers, cancer survivors, and experts in the areas of oncology, health system policy and administration, performance measurement and health services research.

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Disclaimer

The materials in this report summarize the proceedings of the CQCO 2014 Signature Event held in Toronto on November 19, 2014. The CQCO has made every effort to make sure that these materials represent an accurate summary of the proceedings. Cancer Care Ontario (CCO) does not make any representation or warranty as to the completeness, accuracy or currency of the information contained in this report, including, without limitation, any information derived from data sources.

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Executive Summary

The Cancer Quality Council of Ontario (CQCO) is an arm's length advisory group that was established in 2002 to guide Cancer Care Ontario and the Ministry of Health and Long Term Care in their efforts to improve the quality of cancer care in Ontario. Our mandate is to monitor and publicly report on the quality of cancer services in Ontario and to improve cancer system quality by identifying quality gaps and, through the use of international expertise and advice, commission special studies to address them.

The CQCO Signature Event series is one of four key tools used to achieve its mandate. The annual Signature Event brings practice leaders, policy makers, providers, patient and family representatives together with international and national experts to provide practical solutions to address a quality gap and identify areas of opportunity to improve the quality of health services delivery within the Ontario context.

The CQCO's eleventh Signature Event, *Safety is Quality: Strengthening the culture of patient safety in Ontario's cancer system for improved patient care*, was held in Toronto on Wednesday November 19, 2014. With a view of addressing important quality gaps in Ontario's cancer system, the 2014 CQCO event focused on the culture of patient safety in the cancer system. The event objectives were to:

- Discuss opportunities to create a culture of safety within the cancer system as well as address safety for care in the home and community for cancer patients;
- Discuss promising and practical solutions from international jurisdictions and local innovations that address patient safety;
- Discuss the role of Cancer Care Ontario in providing safe care to patients including reporting for quality improvement as well as providing tools for ensuring safe and effective care that is patient-centred.

The November 19, 2014 CQCO event opened with a patient story from a cancer survivor sharing her journey with cancer and the many challenges she faced trying to feel and keep her family safe during treatment. Then the Chair of the CQCO delivered an overview of the current state of safety in Ontario's cancer system and discussed the role of Cancer Care Ontario in the provision of safe care to patients. The overview was followed by several presentations designed to achieve the event objectives listed above. Specifically, presentations included an international case study from Scotland on their experience implementing a nation-wide patient safety program in partnership with the Institute for Healthcare Improvement (IHI), lessons from the aviation industry and from several demonstration projects across the United States on changing culture to improve safety. Further presentations were delivered in the form of short case studies of the impact of culture on the implementation and sustainability a peer review program in radiation oncology in two local cancer centres. The day also featured a number of interactive components including a rapid rounds session with local and provincial presentations on tangible solutions for embedding a culture of safety within an organization, the community

and provincially through incident reporting learning systems. Lastly, there was a dynamic panel discussion on strengthening patient safety in the home and community shared from several different perspectives.

To increase the engagement of the audience in discussing opportunities to create a culture of safety in the cancer system, there were two breakout sessions scheduled during the day – one in the morning and the other during the afternoon. The first breakout session focused on identifying areas and opportunities for Cancer Care Ontario (CCO) to provide leadership for improved patient safety as well as the actions needed to embed a culture of safety in the cancer system. The afternoon breakout sessions built on the panel's conversation about patient safety in the home and community and the discussion of enhancing reporting of incidents and near misses among patients and community partners such as community pharmacists. The event was concluded with closing remarks from CCO's President and Chief Executive Officer, expressing CCO's commitment to embedding a culture of patient safety in the cancer system.

Based on the themes that emerged from the presentations and discussions at the November 19, 2014 event, the CQCO identified the following action-oriented recommendations for improved patient safety in the province

1. **Prioritization of Patient Safety**
    a. Create a model or framework to guide implementation of interventions that are designed to improve patient safety across the province.
    b. Provide system level leadership and coordination by establishing and articulating specific goals and thresholds for the reduction of adverse events across the province.
    c. Enhance the culture of patient safety through implementation of non-punitive approaches for incidents and near misses reported.

2. **Measurement and Reporting**
    a. Provide technical support, where needed, for the development of standard metrics for patient safety across Ontario
    b. Leverage and align existing reporting structures to build and strengthen metrics for patient safety across the entire continuum of care. For instance:
        i. The National System for Incident Reporting (CIHI), Canadian Medication Incident Reporting and Prevention System (ISMP Canada), etc.
    c. Leverage and streamline existing solutions for feedback from patients and caregivers to report incidents that might happen in the home. For instance:
        i. Consumer reporting tool supported through the Institute for Safe Medication Practices (ISMP).

3. **Accountability**

a. Advocate for the creation of clear delineations of roles and responsibility for health workers providing care or services to cancer patients outside the cancer centre.
b. Ensure accountability through measures that address patient education, adverse events and medication errors.
c. Use funding accountability structures as an incentive to improve quality and patient safety while simultaneously increasing responsibility of staff provider.

4. Patient Engagement and Support

a. Facilitate the development of patient-centred resources to inform patients of common side effects of take home therapies and effective self-management strategies.
b. Leverage and spread existing solutions to address challenges faced by First Nations, Inuit and Métis other under-served Ontarians living in rural and remote areas to enhance monitoring and 24-hour support for cancer patients using take-home therapies. For instance:
    i. Facilitate the use of mobile technologies and web-based platforms used by the Ontario Renal Network to connect patients to Renal Care Staff and track patient progress; and
    ii. Draw on programs operated through the Ontario Telemedicine Network (OTN) and Telehealth Ontario to provide 24-hour access to a health care provider.

5. Supports for community providers

a. Establish partnerships with relevant actors in the system to develop and promote the uptake of resources for community groups such as pharmacists. For instance:
    i. Partner with the College of Pharmacists to create guidelines and E-learning modules for the safe handling and dispensing of oral chemotherapy specifically for community pharmacists.
b. Facilitate the development of resources for primary care providers to effectively support cancer patients in their practice.

6. **System Integration and Transitions**

a. Facilitate the standardization of discharge and follow-up procedures across the system for patients taking systemic therapies at home. For instance:
    i. Collaborate with community health care providers such as local community care access centres and primary care providers to offer support for cancer patients following discharge from cancer centre.

1. Background

The Cancer Quality Council of Ontario (CQCO) is an arm's length advisory group that was established in 2002 to guide Cancer Care Ontario and the Ministry of Health and Long Term Care in their efforts to improve the quality of cancer care in Ontario. Our mandate is to monitor and publicly report on the quality of cancer services in Ontario and to improve cancer system quality by identifying quality gaps and, through the use of international expertise and advice, commission special studies to address them.

The CQCO Signature Event is one of our four key tools to achieve our mission. The other three tools are:

- The **Cancer System Quality Index**, which is an interactive web-based public reporting tool, released annually since 2005 and tracks Ontario's progress towards better outcomes in cancer care and highlights where cancer service providers can advance the quality and performance of care. More information can be found at here.
- An annual competition, first held first in 2006, the **Quality and Innovation Awards,** which encourage and recognize significant contributions to quality and innovation aimed to enhance and improve the delivery of cancer care across the province. The Awards are sponsored by the CQCO, Cancer Care Ontario and the Canadian Cancer Society - Ontario Division. More information can be found at here.
- An annual **Programmatic Review** that brings international experts to Ontario to share their best practices and review progress, analyze effectiveness being made by existing cancer system programs (or informing an emerging program).

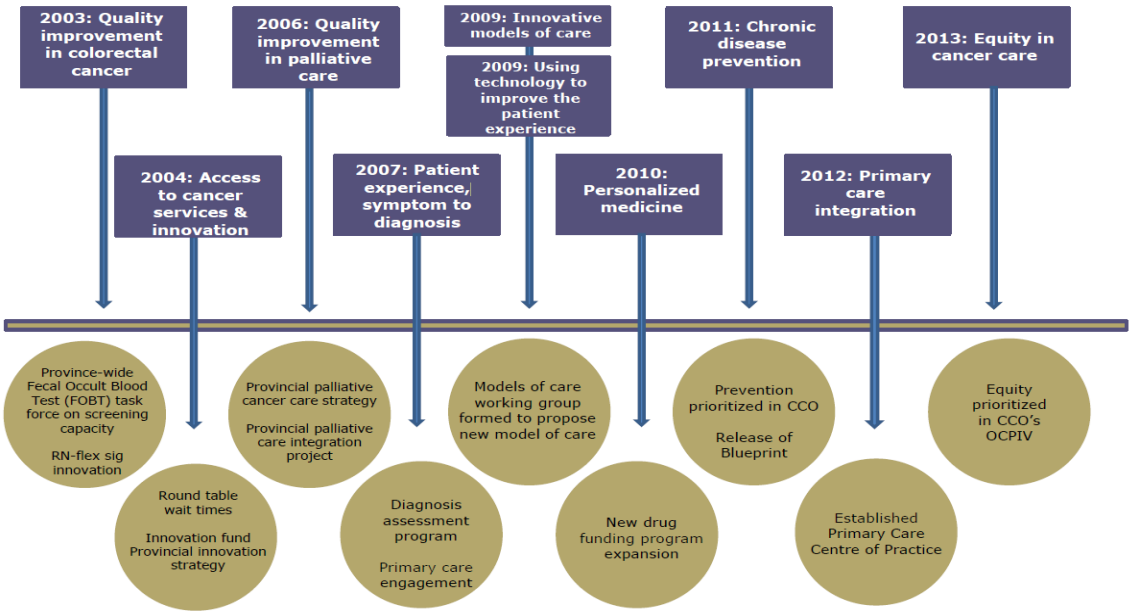
The CQCO incorporates national and international benchmarking tools in all of its products to help monitor, report and enhance the performance of the Ontario cancer system.

2. Introduction

2.1. CQCO Signature Event Series

The CQCO Signature Event series is one of four key tools used to achieve its mandate. The annual Signature Event brings practice leaders, policy makers, providers, patient and family representatives together with international and national experts to provide practical solutions to address a quality gap and identify areas of opportunity to improve the quality of health services delivery within the Ontario context. Figure 1 shows the themes and outcomes from CQCO Signature Events from 2003 to 2013.

Figure 1: *Areas of focus and outcomes from Signature events from 2003-2013*



2.2. CQCO's 11th Annual Signature Event: Patient Safety in the Cancer System

The CQCO's 11th annual signature event, titled *Safety is Quality: Strengthening the Culture of Patient Safety in Ontario's Cancer System for Improved Patient Care*, was held on November 19th, 2014 in Toronto, Ontario. The specific objectives of event were to:

- Discuss opportunities to create a culture of safety within the cancer system as well as address safety for care in the home and community for cancer patients;
- Discuss promising and practical solutions from international jurisdictions and local innovations that address patient safety;
- Discuss the role of Cancer Care Ontario in providing safe care to patients including reporting for quality improvement as well as providing tools for ensuring safe and effective care that is patient-centred.

The purpose of this report is to provide a summary of the event's proceedings and recommendations drafted by the Council based on input from international and local experts, panel discussions and participant discussions in breakout groups.

The 2014 Signature Event topic of patient safety identified by the Council was supported by evidence presented in the 2013 public release of the Cancer System Quality Index (CSQI – www.csqi.on.ca) and the safety related system performance measures presented, which included adverse events following treatment. In addition, the development and planning of the event coincided with the creation of the soon-to-be-released fourth iteration of the Ontario Cancer Plan (OCPIV), a plan

that guides CCO's priorities for 2015-2019. The OCPIV was shaped in part by quantitative data from the CSQI 2013, in addition to a series of intense and thorough consultations with regional stakeholders to identify system-level challenges and barriers to improving the quality of cancer care. As a result, the event's theme and objectives took the following system-level challenges into consideration:

- Fragmented governance and accountability around safety;
- Absence of thresholds, benchmarks and safety standards for some services
- Absence of peer review for some processes
- Absence of point-of-care delivery tools for embedding guidelines into clinical practice;
- The system is currently reactive and not proactive and incorporates risk that arises from system change;
- Adherence to guidelines, laws and professional obligation is not being consistently measured;
- Limited and inconsistent incident capture and reporting across programs, partially due to fear of "blame and shame";
- Limited analysis to identify and address areas for improvement

The November 20, 2014 agenda (see Appendix I) outlined an event that integrated the participation of cancer survivors and caregivers into the discussion. To highlight the importance of the person-centred perspective, the event was opened by a patient who shared the story of her experience receiving cancer care in Ontario and the incidents related to safety that occurred throughout her journey.

3. CQCO Recommendations for Strengthening the Culture of Patient Safety in the Cancer System

As a result of the event, the CQCO's identified key actions in the form of recommendations that, if implemented, will enhance safety of care delivered to cancer patients in Ontario. Event speakers and participants provided valuable contributions throughout the day that provided the basis for the CQCO recommendations:

1. Prioritization of Patient Safety

a) Create a model or framework to guide implementation of interventions that are designed to improve patient safety across the province.
b) Provide system level leadership and coordination by establishing and articulating specific goals and thresholds for the reduction of adverse events across the province.
c) Enhance the culture of patient safety through implementation of non-punitive approaches for incidents and near misses reported.

2. Measurement and Reporting

a) Provide technical support, where needed, for the development of standard metrics for patient safety across Ontario

b) Leverage and align existing reporting structures to build and strengthen metrics for patient safety across the entire continuum of care. For instance:
   i) The National System for Incident Reporting (CIHI), Canadian Medication Incident Reporting and Prevention System (ISMP Canada), etc.
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3. Accountability

a) Advocate for the creation of clear delineations of roles and responsibility for health workers providing care or services to cancer patients outside the cancer centre.
b) Ensure accountability through measures that address patient education, adverse events and medication errors.
c) Use funding accountability structures as an incentive to improve quality and patient safety while simultaneously increasing staff responsibility.

4. Patient Engagement and Support

a) Facilitate the development of patient-centred resources to inform patients of common side effects of take home therapies and effective self-management strategies.
b) Leverage and spread existing solutions to address challenges faced by First Nations, Inuit and Metis other under-served Ontarians living in rural and remote areas to enhance monitoring and 24-hour support for cancer patients using take-home therapies. For instance:
   i) Facilitate the use of mobile technologies and web-based platforms used by the Ontario Renal Network to connect patients to Renal Care Staff and track patient progress; and
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5. Supports for community providers

a) Establish partnerships with relevant actors in the system to develop and promote the uptake of resources for community groups such as pharmacists. For instance:
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6. **System Integration and Transitions**

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i) Collaborate with community health care providers such as local community care access centres and primary care providers to offer support for cancer patients following discharge from cancer centre.

4. Introduction to the event

4.1. What are we talking about? The need to address patient safety across the continuum of care to ensure the delivery of safe care to all cancer patients in Ontario

Lillian Clarke, cancer survivor and member of CCO's Patient and Family Advisor Committee (PFAC), welcomed everyone to the CQCO's 11th Annual Signature Event, *Safety is Quality: Strengthening the culture of patient safety in Ontario's cancer system for improved cancer care*. Following her welcome, Ms. Clarke proceeded to set the tone and frame of the event by telling the story of her journey with cancer and the many challenges she faced trying to feel and keep her family safe during her treatment.

Ms. Clarke was diagnosed with thyroid cancer in 2008 following the removal of her thyroid. Her first challenge came almost immediately following her diagnosis and initial surgery. Ms. Clarke was told her treatment would include thyrogen injections, at the hospital, that she would need to purchase at her own pharmacy and at her own expense. Upon arrival to the hospital, on the day of her treatment, not only was there no record of her appointment for that day, but she was also informed that the thyrogen, which she was instructed to purchase at her pharmacy at her expense, was in fact coming from the hospital's pharmacy while she waited. However, she had already purchased the thyrogen and had brought it with her to the appointment.

The next phase of Ms. Clarke's treatment involved radioactive iodine capsule treatment, usually administered in a hospital. Patients are typically isolated, ideally in a room in the hospital with lead lined walls, for 5 days until their bodies are no longer radioactive. Upon arrival at the hospital, once again they did not have her appointment listed in the schedule, but regardless, proceeded with her treatment. The hospital's only isolation room was not available, as Ms. Clarke was informed of ahead of time, so Ms. Clarke was sent home, through a backdoor of the hospital, following her treatment despite having expressed her concerns, many times, about the safety of her family and exposing them to the radiation. As a result, Ms. Clarke decided to stay the five isolation nights, alone in a hotel room to avoid the risk of exposing her family to radiation. Further challenges were encountered, two days after her treatment, when she was still radioactive and had to return to the hospital for follow up lab work. She discovered that three of the staff she would interact with were pregnant and unaware that she was radioactive.

The challenges Ms. Clarke experienced had led her to be concerned about the safety and the effectiveness of the treatment she was receiving. She described having feelings of abandonment and isolation as a result of the hospital's response

to her concerns and her experiences with the staff. Ms. Clarke's story served to highlight the challenges, stresses and confusions patients and their families can face during treatment. In view of the event's objectives, she acknowledged that there were opportunities to improve the safety of care for cancer patients and the responsiveness of the system to the patient's needs.

4.2. Patient safety in the cancer system: Building a culture of safety across the system to improve the patient's experience and avoid adverse outcomes

Virginia McLaughlin, Chair of the Cancer Quality Council of Ontario, introduced the topic of patient safety in the cancer system and provided an overview of the event's objectives. During her introduction, she highlighted the results of the previous Signature Events (see Figure 1, page 7), such as CQCO's 2013 signature event on the topic of health equity which resulted in the inclusion of 'equity' into the upcoming fourth iteration of Cancer Care Ontario's Ontario Cancer Plan as a key priority area to be addressed.

Ms. McLaughlin provided a description of how the topics for the Signature Event are selected based on system gaps identified by the Cancer System Quality Index (CSQI), the CQCO's interactive web-based public reporting tool which highlights the quality and performance of care in the system. A number of safety measures were publically reported in the most recent release, CSQI 2014, that were designed to measure the safety of care predominantly in two key areas of the cancer journey: screening and treatment. In response to the data presented in the CSQI, the Council assigned a rating of "fair" for safety, highlighting that although there are some processes in place to ensure the safety of care delivery, there is still room for improvement.

Ms. McLaughlin noted that safety, that is, avoiding and preventing harm from health care management, has always been a key focus for high performing health care systems around the world. There is evidence that the Ontario cancer system is making strong progress towards being fully responsive to the needs of the patient in ensuring that care is safe as demonstrated by the increasing number of Computerized Physician Order Entry (CPOE) being implemented in Ontario hospitals to reduce errors in prescribed chemotherapy. Additional efforts are required however to reduce the number of hospital visits following adjuvant chemotherapy and during radiation treatment. Though there are many areas of safety that could be addressed, including provider safety, the focus of this Signature Event was ensuring that the delivery of care is safe and patient-centred.

5. System-level planning for patient safety

5.1. People Matter

Hugh McLeod, Chief Executive Officer (CEO) of the Canadian Patient Safety Institute, began his discussion by making reference to the patient safety "harm meter" to highlight the level of harm that patients have been exposed to in the system. His discussion included a reflection on the Institute for Healthcare

Improvement's (IHI) 100,000 Lives Campaign, which was launched in 2005, and was largely driven by a report that, on average there were a 100,000 lives lost in the Unites States' healthcare system that were preventable. Mr. McLeod noted that around the same time that the 100,000 Lives Campaign was launched, Ross Baker (2004) released a landmark study in Canadian patient safety literature, on patient safety in the Canadian healthcare system. The study was focused on inpatient hospital care settings and determined that there were approximately 20,000 avoidable deaths in Canada. Mr. McLeod then concluded his reflection by moving to the present time and highlighting recent system reports from the US that suggest that preventable hospital harm is now the 3rd leading cause of death in the country. As such, the 100,000 deaths have now grown to 400,000.

Having been diagnosed with prostate cancer six years prior, Mr. McLeod spoke from the perspective as the CEO of the Canadian Patient Safety Institute (CPSI) as well as a patient. His experience as a patient afforded him a new view of the health system and the challenges cancer patients face with managing their disease and anxiety. Based on his experience both as the CEO of the CPSI and a cancer patient, Mr. McLeod concluded his remarks by offering his view of five new perspectives to be considered as a part of the future state of the health system:

1. New patient and client perspective: A customer driven approach that emphasizes health outcomes and seamless transitions regardless of location;
2. Healthcare culture perspective: an approach where there is respect, trust and confidence for those people who deliver good care to create a 'prevailing curiosity' concerning what is known and, most importantly, what is yet to be discovered.
3. Healthcare skills and capacity enabling perspective: this includes systems thinking, team learning, collective intelligence and problem solving as well as an integrated knowledge base of evidence derived from processes and outcomes rather than 'blame and shame'.
4. Healthcare structure/value creating perspective: a common language for planning and implementing change to create structure and value.
5. Resources Perspective: resources should be allocated based on continuous capacity planning and improvement, evidence-based decisions and strategic budget oversight.

5.2. Scotland's system-wide patient safety improvement journey: Sharing lessons learned from the Scottish experience

Jane Murkin, Head of Patient Safety and Improvement at the National Health Service (NHS) Lanarkshire in Scotland, began her presentation by describing the context of the Scottish healthcare setting and how the country started on its patient safety improvement journey. The Scottish health system is comprised of 14 health boards and eight support boards. The country's current focus is on integration, health and social care with an aim of partnering with organizations to improve the care of the patient. The Scottish patient safety journey officially started in 2008 when the health minister at that time launched the National Scottish Patient Safety Program. The country, as a whole, partnered with the Institute for Healthcare

Improvement (IHI) to work on achieving their improvement goals, a 15% reduction in mortality and a 30% reduction in adverse events.

The Patient Safety Program marked the first time that the country had come together as a whole to implement an improvement collaborative program rather than simply setting national targets focused on healthcare improvement. The program itself was very ambitious, transformational and achievable within the Scottish context. The aims of the program were all evidence-based and emerged from existing quality improvement work that had already been taking place in the system. The changes that were implemented through the program presented an opportunity to bridge the gap between evidence-based and practice-based care. It used the IHI's model for improvement which was a simple well-known model that was used as a framework to support staff at all level of an organization to implement change.

Ms. Murkin identified several factors that were crucial in making the program the success. The need to strengthen the skill of the workforce to ensure that staff are empowered to test and implement the changes that were required, emerged as one of the key factors needed for successful implementation of the program. As a result, an educational body was created in Scotland to focus on strengthening the skills and knowledge of the staff to build capacity for quality improvement and change. Culture change also played an important role in the success of the program's implementation which was facilitated by clarity of role for staff to increase clinical engagement and ownership of patient safety improvement.

Several lessons emerged from the implementation of the Patient Safety Program including:

1. Increase team ownership of initiatives
2. Achieve reliability in processes prior to spreading them
3. Measure safety and share the data
4. Expand safety into other areas
5. Involve everyone in the change processes
6. Use people ideas – the group knows more than the individual

Scotland continues to strive to integrate patient safety with other initiatives to make it easier for staff to do the right thing. Further, the program looks to make patient safety a strategic priority at all levels, especially at the board level and other levels of leadership. Ms. Murkin concluded her discussion by stressing the important of providing support to staff to carry out the work – this includes support for education and skills development.

Q and A Highlights from System Level Planning for Patient Safety

Empowering patients to speak about patient safety issues

- It is important to involve patients in the design and creation of tools for patient safety;

Involvement of the General Practitioners in patient safety in Scotland

- The UK's Quality Outcomes Framework (QOF) has facilitated a discussion about embedding safety and quality into the system. General Practitioners are required to ensure that they are focusing on the important aspects of quality and care.

6. Changing culture at a system-level

6.1. Patient safety and culture: A 30,000 foot view – lessons learned from the evolution of safety in aviation

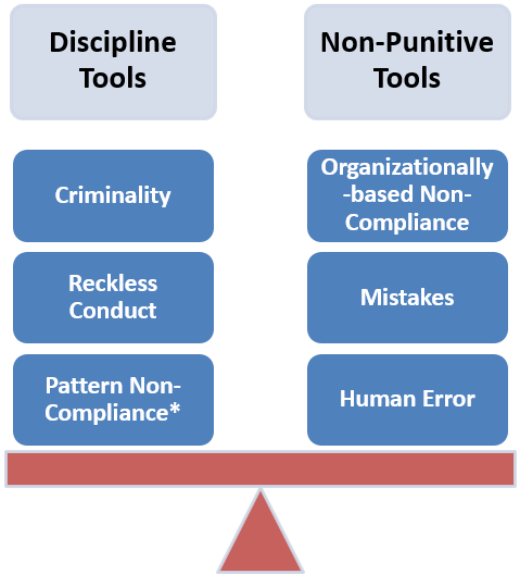
David Deveau, Vice President of Safety, Quality and Environment at Jazz Airlines shared his experience with safety from the perspective of the airline industry. He began his presentation by discussing the evolution of safety in aviation which was catalyzed by critical incidents and accidents across airlines that were leveraged as learning opportunities for improvement. The creation of the Federal Aviation Administration in the United States, was a result of an incident that happened mid-air that lead to a passenger losing his life. Mr. Deveau described the culture of safety in the aviation industry at the time as one that was 'reactive'. As safety in aviation evolved, the ultimate goal of the entire industry became moving towards a system that is more 'proactive' in its response to safety and thereby more successful in predicting potential incidents in order to prevent them from occurring.

The evolution in the aviation industry resulted new ways of managing safety, including new techniques for investigation. One such technique was the development of a safety management system (SMS) or an enterprise system for safety. Mr. Deveau described an SMS as a series or a set of policies and processes that were integrated throughout the organization. He highlighted several distinguishing factors of the SMS used in aviation today that are fundamental to its success. Firstly, the SMS is risk-based, meaning that it highlights things that represent the greatest risk and hazard in the system. Secondly, the SMS is evidence-based, or it makes note of what is important to the system based on the data that has been collected. An SMS is also performance based which not only emphasizes compliance but also a risk-based approach. Finally, the SMS is also enterprise in nature and culture based, which is vital for the success of any SMS designed to improve safety.

Mr. Deveau emphasized the importance that using a Just Culture approach has had in transforming the culture of the industry and Jazz Aviation, as an organization, specifically. He defined Just Culture as an organizational culture that recognizes that even the skilled, knowledgeable and competent professional will inevitably make mistakes and that professionals will develop unhealthy norms, shortcuts and rule violation, however there must be zero tolerance for reckless behavior. Just Culture balances the need to hold people accountable for unacceptable conduct with

non-punitive management of predictable human performance issues often organizationally caused. Having an organizational culture that is 'just' enables safety improvement that is centred on continuous learning for the organization and individuals.

Figure 2: *Balancing the need to hold people accountable for unacceptable conduct with non-punitive management*



Source: Deveau (2014), *"Patient safety and culture: A 30,000 foot view – lessons learned from the evolution of safety in aviation."* (Presentation at CQCO 2014 Signature Event), Slide 9, Toronto, November 19, 2014.

Given the nature of culture as being non-homogenous and non-segmented, making changes to the culture of an organization can be challenging, however Jazz has been successful with the use of a non-punitive approach. Mr. Deveau concluded by sharing several things that worked well for Jazz Aviation in their attempt to embed a culture of safety throughout their organization some of which included the following:

- Non-punitive organizational response has been tested many times and has stood the test of time;
- Safety is not used as a pawn in company-labour matters (such as contract negotiations);
- Data and information systems provide analysis to target improvement based on fact, not emotion;

6.2. System-level enablers for culture change: Mindfully creating culture to improve the safety of care

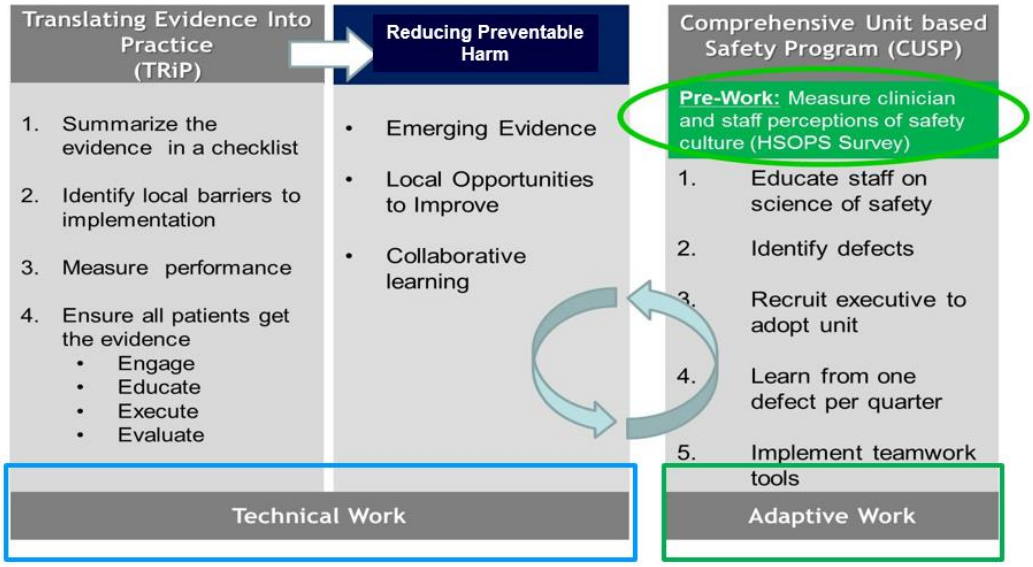
Dr. Sallie Weaver, Assistant Professor in the Department of Anesthesiology and Critical Care Medicine at Johns Hopkins Medicine and Armstrong Institute for Patient

Safety and Quality, shared lessons learned from two national demonstration improvement projects that the Armstrong Institute has been involved in. The first project was the Leadership and Accountability Demonstration project that is currently ongoing and is being done in partnership with VHA, Inc., and the Centre for Medicare and Medicaid Services' (CMS) Partnership for Patients project. Dr. Weaver explained that the CMS Partnership for Patients project is one of the primary, federally funded projects to improve patient outcomes and reduce preventable harm nationally. The goals of this project were to reduce harm in 10 areas by 40% and reduce readmissions by 20% in three years. The second project was a national project that focused on the reduction of surgical site infections within a period of 24-months that involved over 300 teams working in over 190 hospitals enrolled across the entire county.

Dr. Weaver provided an overview of the work undertaken by the Armstrong Institute. The Armstrong Institute is the central body that oversees patient safety and quality for the Johns Hopkins Health System which consists of six acute care hospitals, a community physicians group, and a home care group that operate hospice care programs. The Armstrong Institute also has a research section that has an academic focus, which includes evidence-based approaches to culture change for health system improvement. As the Armstrong Institute focuses on building the evidence base concerning approaches to developing and sustaining cultures of safety in health care, Dr. Weaver began the discussion by highlighting five myths about organizational culture change that arise as barriers for improvement from the two national projects and additional research.

The first myth focused on the WHO surgical checklist and the idea that the implementation of the checklist was solely responsible for its uptake and improved patient outcomes. Debunking the myth that checklists and other similar technical interventions alone are adequate means to change culture and daily practice, Dr. Weaver noted the important role of the Armstrong Institute's model to improve care (figure 3). The Institute's model emphasizes the translation of technical evidence into usable, clear tools that are paired with adaptive interventions designed to improve the work environment, teamwork, and culture. The model emphasizes the adaptive work that accompanies the tools and processes as the mechanism that moves culture, creates new norms and habits that are important to provide cues about the relative priority of safety.

Figure 3: *Johns Hopkins Medicine Armstrong Institute Model to Improve Care*



Source: Weaver (2014), *"System-level enablers for culture change: Mindfully creating culture to improve the safety of care."* (Presentation at CQCO 2014 Signature Event, Slide 11, Toronto, November 19, 2014).

The second myth was the notion that there are good cultures and bad cultures. Dr. Weaver described this as a misnomer due to the multifaceted nature of culture that is comprised of six core pieces including:

1) Communication patterns and language
2) Feedback, reward, and corrective action practices
3) Formal and informal leader actions and expectations
4) Teamwork processes
5) Resource allocation practices
6) Error-detection and correction systems

The third myth highlighted by Dr. Weaver was the idea that organizational change is only about learning new ways of doing things. She referenced a classic model of organizational change developed by Lewis et al. (1951) that highlights the importance of first unlearning and then relearning new ways of doing things to bring about change. There are three phases in the model the first being "unfreeze", which refers to the motivation to change as well as creating psychological safety to overcome change anxiety. The second and third phases are "learn and re-balance" and "rebalancing over time" respectively. The first relates to learning new concepts and the second being reframing and reinterpreting the old. Dr. Weaver argued that often improvement teams place greater emphasis on the second phase of the model that is, learning, with little to no attention or time invested in the unfreezing phase. Dr. Weaver emphasized a need to focus on the "unfreezing" phase first, which provides an opportunity for individuals involved to understand why there is a need to change and the notion that the evidence is continuously evolving.

The fourth myth highlighted was that acceptance is equal to change. Dr. Weaver challenged this myth by referencing several studies from her research that support the need to implement mindful interventions that move good practices into daily routine. Similarly, the fifth and final myth highlighted by Dr. Weaver was the notion that there is an effective prescription for cultural change. Results from her work with the national projects through the Armstrong Institute as well as a systematic review that included 33 studies published in 35 papers demonstrated that there is no prescription or guarantee that results from a particular action in one setting will be the same in another. Results from the systematic review indicated that the majority of culture change interventions were bundled interventions that combine multiple interventions and approaches together. 57% of the studies reviewed used combination or bundled improvement strategies and 61% integrated some form of training or communication tools – which is one of the key adaptive work highlighted earlier. There was also evidence of improved patient outcomes linked to improvement in healthcare workers perceptions of safety culture.

Following her discussion of the key myths of organizational change, Dr. Weaver shared several best practices and factors for effective behavior and culture change. A number of these essential factors that shape change include:

- Benefits (and perceived benefit to harm ratio): the consequences of performing recommended response;
- Subjective norms: how it is perceived that others have acted in similar situations
- Attitudes: the belief that the desired behavior will be effective (perceived response efficacy);
- Intention and mindfulness: how attention is allocated to this intention to carry out the desired behavior;
- Affordances and cues to act: internal and external features that remind and motivate individuals to engage in desired behavior.

Dr. Weaver also identified several facilitators that, through her work, have been proven to be effective in sustaining change. Facilitators would include structural change strategies such as team composition, role clarity and task re-design. Other facilitators included process change strategies (for instance, standardized communication), measurement and continuous improvement strategies (such as audits for improvement) and social leadership strategies (including role modeling). Dr. Weaver concluded by stating that, overall, really changing culture is about mindfully managing and creating the desired culture. Further, to "to drift is human" as people drift into failure over time. When attempting to engender culture change, consideration should be given to addressing changes through processes, measurement and continuous feedback. There are also opportunities to address change through leadership, role-modeling, and coaching.

Q and A Highlights from Changing Culture at a System-Level

Sharing safety data in an organization and across and industry

- Jazz aviation has included a feedback cycle as a part of their SMS framework. Some of the challenges experienced are related to engaging staff to share what they have learnt. To overcome these challenges, the organization has implemented safety briefs that are incorporated into training and internal communications such as newsletters.
- Johns Hopkins has used a clinical communities strategy where teams come together once every month to discuss errors and glitches that have happened to share strategies across all the entities in the health system.

6.3. The impact of culture on the implementation and sustainability of peer review programs in radiation therapy

Dr. Craig McFadyen, CQCO member and Regional Vice President of the Carlo Fidani regional cancer centre, facilitated a discussion on how culture impacts the implementation and sustainability of peer review programs in radiation therapy. During his introduction, Dr. MacFadyen highlighted that the Carlo Fidani cancer centre has a very robust peer review process for radiation oncology where all radical courses are subject to review by a multidisciplinary team of providers. This approach has been leveraged and expanded to other areas such as systemic therapy and is based on a culture of trust among all the providers involved.

Dr. Woodrow Wells

Dr. Woodrow Wells, the Physician Lead for Radiation Oncology at Southlake Regional Cancer Centre, shared the experience of his centre with the implementation of a peer review program for radiation oncology and how they have successfully be able to peer review 100% of all radical cases. Dr Wells began by noting that peer reviews are conducted together by an interdisciplinary team for two hours at noon every Tuesday and Thursday. The centre reviews approximately 2,000 courses of treatment every year. Dr. Wells identified several factors that were foundational to local success:

- Encourage the questioning environment
- Safe forum to develop and diffuse the departmental norms and standards
- Creating the thinking workplace: balancing policies, rules, and engineered processes vs. developing professionals autonomy and engagement
- Therapists role in simplifying complexity for the patient;
- Peer review processes makes quality and patient safety everyone’s business.

In addition to the list highlighted above, there were several other factors noted by Dr. Wells including the advantage of having a youthful workforce and changes in

physician practice to openly discuss the proposed course of a patient's treatment with their colleagues. Further, having leadership that is committed to the program and an engaged frontline staff is fundamental to the program's success.

Dr. Jason Pantarotto

Dr. Jason Pantarotto, Chief of the Division of Radiation Oncology for The Ottawa Hospital, shared the experience of The Ottawa Hospital in implementing a peer review program for radiation oncology. Dr. Pantarotto started by noting that The Ottawa Hospital had 40% of radical cases peer reviewed during a 12-month period (also reported in CSQI 2014). Several challenges faced by the cancer centre were identified in implementing the peer review program, some of which included the size of the cancer centre and patient volume. The Ottawa Hospital has 5,000 new patients per year and 4,200 treated cases – roughly 2,300 of these cases are eligible for peer review annually. The peer review strategy consists of weekly rounds and weekly specific Quality Assurance rounds that are either disease specific or technique specific. The centre has also implemented a program to recognize the 'Doctor of the Week' as an incentive for improved performance and increased clinician engagement.

Dr. Pantarotto highlighted several opportunities to increase the number of cases peer reviewed including; error reduction, enhanced discussion amongst peers, standardization of practice, identification of high risk vs low risk treatments and overall workflow review. He concluded by listing five steps to take in order to establish adoption of peer review programs:

- Establish local champion(s)
- There is no "one size fits all" solution
- Peer review is at least as important as other clinical activity
- The risk of error is likely different for different plans (unable to quantify at the present time)
- There may be more than 1 "right" way but there can't be five.

7. Morning Breakout Group Discussions

Attendees were assigned to a breakout group with a diverse range of expertise. Having groups with a broad knowledge base allowed for discussions on priorities for action at the system level to embed a culture of safety in cancer care. Groups were given 30 minutes to consider the following two questions two questions:

- What are the actions needed to embed a culture of safety across the Ontario cancer system?
- Where can CCO provide leadership for improved patient safety?

Following the breakout discussion, one individual from each of the 10 groups then reported their "big idea".

'Big ideas' from Breakout Group Discussions:

- In driving culture, coming to common definitions and a common framework are a key next step to get started.
- Embed patient safety in the strategic direction for the province.
- Increase the engagement of patients in treatment planning and culture change activities.
- Increase focus on strengthening integration between pieces within CCO and beyond CCO.
- CCO should act as a change agent for data collection and the measurement of patient safety throughout the province.
- Ensure the integration of patient safety as a theme in relevant projects with measurable and evidence-based targets.
- Strengthen patient safety reporting to improve communication and remove silos.
- Shift focus of quality away from volume and access and use funding as a lever to improve patient safety and the quality of care.
- Implement patient safety walkabouts, create clear role definition and bridge cultural differences via communication.
- Apply peer review system to other disciplines and more patients

8. Improving patient safety in cancer care

8.1. The Quality Management Partnership: A new partnership to improve patient safety and quality and improve quality of care in Ontario

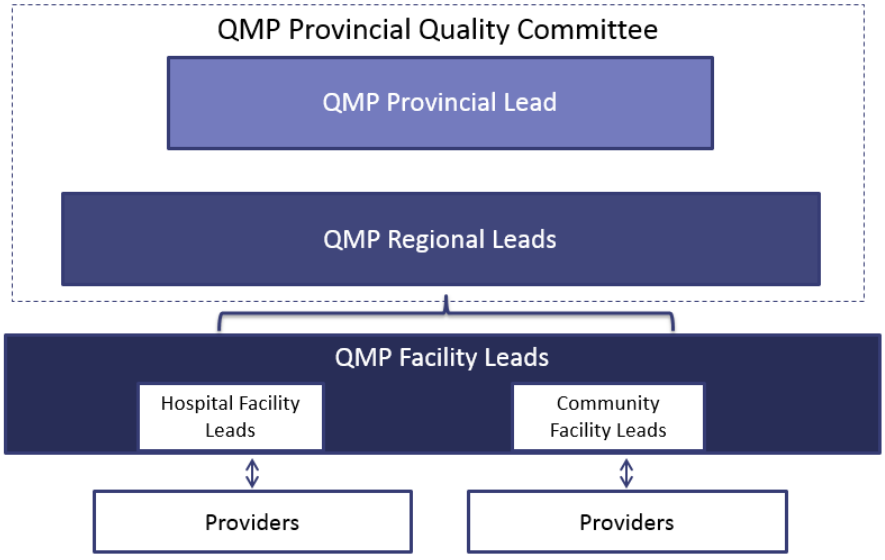
Lynn Guerriero, Managing Director of Cancer Screening at Cancer Care Ontario and Wade Hillier, Director of the Quality Management Division at the College of Physicians and Surgeons of Ontario (CPSO), presented on the Quality Management Partnership (QMP) which is a new initiative and partnership between CPSO and CCO. Ms. Guerriero provided an overview of the partnership. The QMP began in March 2013, when a formal announcement was made by the Ministry of Health and Long Term Care (MOHLTC) regarding the formal partnership between CCO and the CPSO to develop three quality improvement programs in the areas of mammography, colonoscopy and pathology. These three areas were chosen as there were existing infrastructure and programming that could be leveraged in the development and implementation of quality improvement initiatives in each area.

Ms. Guerriero discussed several drivers for the partnership which included past quality and safety incidents, variation in quality and care, variation in processes to proactively identify quality concerns and Ontario's Action Plan For Health Care which is very explicit about improving the quality of care and decreasing variation.

The goals of the partnership are to improve the quality of patient care at the physician and facility levels and the health system at large. A road map was created to guide the overall development of the initiative. The first phase of the initiative will focus on designing quality management programs/interventions for each of the three areas identified, followed by the integration of data gathering systems. These two phases will be followed by the implementation of a quality assurance process at both the provider and facility levels. There will be a focus on performance improvement that will be aligned with peer-led approaches and a particular emphasis on non-punitive approaches in addressing errors. The final phase of the initiative will look at linking the reporting of quality improvement opportunities. Stakeholders include patients, providers, facilities and healthcare system administrators.

A Quality Management Model (figure 4) was developed to be used for each of the three areas of focus. The model highlights several layers of leadership, specifically, clinician and peer leadership, to oversee the quality management and quality assurance processes. The model will not replace existing accountability structures within hospitals and facilities but rather will be effective in assisting to identify individuals who will receive reports. The interventions to be implemented will be done at the facility level and overseen by the QMP facility leads. There will be no requirements for interventions at the provincial and regional levels however support will be available should there be a need to implement interventions beyond the facility level.

Figure 4: *The Quality Management Model*



Source: Guerriero & Hillier (2014). *"Quality Management Partnership: A new partnership to improve safety and improve quality of care in Ontario."* Slide 12. Toronto, November 19, 2014

In order to align the QMP with existing quality improvement programs across the province, one of the foundational principles has been to leverage and align with

existing work and infrastructure. As such, the initiative seeks to align with initiatives from the MOHLTC, CCO programs, CPSO Peer and Facility Assessments, as well as provincial and national quality initiatives among others. Ms. Guerriero concluded by noting that much of the initiatives future work will be built around fostering a culture of quality improvement at the facility and provider level.

8.2. Rapid rounds: Systematic consideration of patient safety in planning: Learning systems for embedding safety into service delivery

The rapid round discussion was facilitated by the CQCO Chair, Virginia McLaughlin, who provided an introduction of the topic being discussed that is, learning from incident reports. Ms. McLaughlin facilitated the Question and Answer session which followed this discussion.

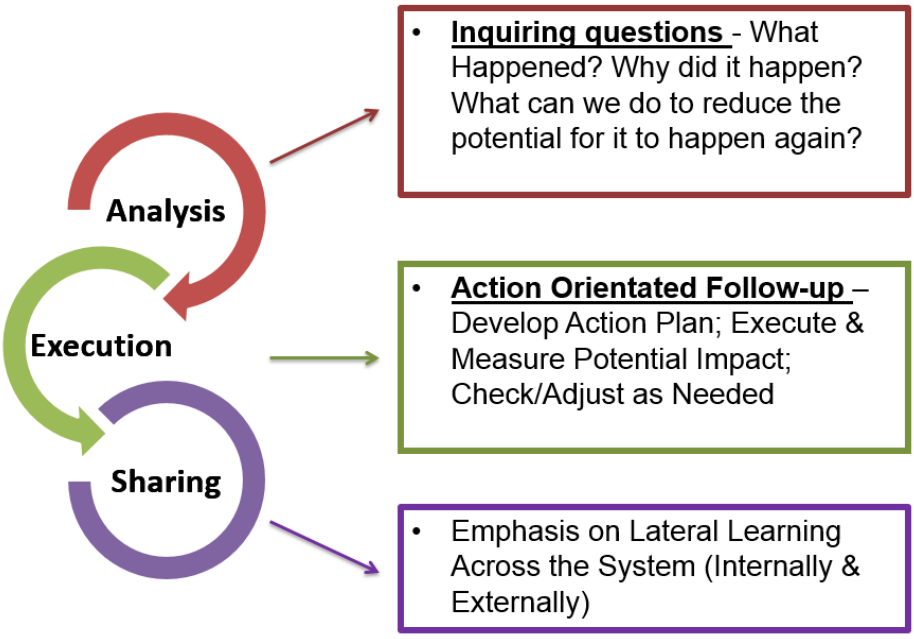
Debbie Barnard

Debbie Barnard, Chief Quality and Safety Officer at Health Sciences North in Sudbury, presented an overview of the reporting and learning system within her organization. The hospital's reporting system was largely influenced by the 2011 Excellent Care for All Act. The ultimate goal of the hospital was to create a safer space for both staff and patients.

Health Sciences North has consistently worked towards improving and enhancing reporting to identify 'good catches' and near misses that can be used as great learning opportunities. To accomplish this, the organization has revised their internal infrastructure to ensure that key players are engaged. The organization has continuously discussed how to have a deeper understanding of the hazards within the organization. Further, leadership engagement and sharing data at all levels of the organization has been tangible.

Ms. Barnard also highlighted that the organization learned how to analyze the data from a learning perspective, rather than from a blame perspective (figure 5). The organization has also focused on action oriented follow-up as well as ensuring that the learnings are shared. The organization has been fostering a culture of sharing both internally as well as externally which has been done through engagement with the Institute for Safe Medication Practices Canada (ISMP Canada).

Figure 5: *Health Sciences North Incident Analysis and Learning Model*



Source: Barnard (2014*). "Creating a Patient Safety/Risk Learning System."* Slide 6. Toronto, November 19, 2014.

Gaylene Medlam

Gaylene Medlam, Co-chair of the Radiation Incident Safety Committee for CCO, shared the experience of incident reporting and learning from a provincial perspective. Ms. Medlam began by providing contextual information on the Radiation Incident Safety Committee which was started in 2007 by CCO's radiation treatment program. The committee's membership comprised of representatives from each of the cancer centres and radiation treatment programs within Ontario. A radiation incident lead was created for each of the treatment programs shortly after the birth of the committee.

Starting in 2007, the committee began gathering crude data on incidents and developing a culture of safety to share learnings across all the existing treatment programs. One of the largest challenges in sharing was the language barrier encountered, as not all the programs spoke the same language when reporting incidents. To facilitate the growth of culture built on learning, Ms. Medlam described the Committee's creation of a 24-hour turnaround system for sharing critical incidents related to equipment or process issues with high potential for repetition. Data that is shared through this system in anonymized before sharing widely.

In 2011, it was decided that the available data needed to be further analyzed. As a result, the Committee created a list of areas and different categories for reporting across all Centres. The Committee is currently preparing to work with the Canadian Partnership for Quality Radiotherapy (CPQR), which is in the process of defining the taxonomy for incident reporting to bridge the language gap. Moving forward the

Committee will be able to share data with the CPQR as they work with the Canadian Institute for Health Information (CIHI).

Dr. Roger Cheng (PharmD)
Dr. Roger Cheng, Project Leader for ISMP Canada, presented on the available learning systems and tools available to share incidents at a community and national level for both pharmacists and the consumer. Dr. Cheng provided a description of the incident reporting system and online incident reporting portal for community pharmacy, as well as an analysis platform for incidents. An online portal is also available for consumers to report incidents that they may have at home. It contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS).

Dr. Cheng described ISMP Canada as having the greatest interest in understanding the incident and how it happened, so they focus on a non-punitive approach to learn from medication incidents. To that end, a team of multidisciplinary health professionals and medication experts are assembled to analyze relevant data from the incident and provide their perspective on the cause. Multiple analysis strategies are used to ensure the effective utilization of information – both quantitative and qualitative. Learning is facilitated through the use of several knowledge transfer and exchange strategies such as a medication safety newsletter that is distributed all across Canada. Some tools have been developed specifically for the community pharmacist including a medication safety self-assessment module. Dr. Cheng concluded that incident reporting independent of learning and quality improvement is insufficient to engender change. Rather, expert analysis and learning leading to quality improvement is essential.

Q and A Highlights from Rapid Round Session

Lessons learned from implementing learning systems for patient safety

- It is important to model the behaviours that is being shared with staff. Staff are accustomed to hearing leaders talk about what should happen however they often times do not see these behaviours happening.

Systematic ways of addressing adverse events identified in reports from patients

- It is important to be respectful of patient feedback. This may require health care practitioners to learn how to appropriately communicate with patients.

Health Sciences North has begun to see reports from patients as a trigger tool that are discussed at the board and senior management level as well as at internal patient safety and quality networks.

9. Panel Discussion: Patient safety in the home and community

9.1. Supporting patients at home: Challenges and solutions for strengthening patient safety in the home and community

The panel discussion was facilitated by the Co-Chair of CCO's Patient and Family Advisory Committee (PFAC), Joanne MacPhail. Ms. MacPhail introduced the topic of patient safety at home and in the community as well as the panel speakers and the perspectives that they would represent.

Andrew Choate

Andrew Choate, a cancer survivor and a member of Cancer Care Ontario's Patient and Family Advisory Committee, provided an overview of his experience as a cancer patient receiving oral chemotherapy and the challenges, from his perspective, with outpatient care. Mr. Choate has a rare form of Hodgkin's lymphoma and received combination chemotherapy. He completed a solo Rituximab maintenance therapy. The chemotherapy he received was at home and also as an outpatient. Mr. Choate described the challenges he experienced while receiving treatment, the biggest impact being his inability to lead a normal life.

Mr. Choate is an advocate for moving care to the community and where possible into the patient's home to contribute greatly to improving the quality of the patient's life. He acknowledged that moving care into the community and home requires care, including a thorough assessment of the patient's ability or their support system to apply the necessary rigor to the home setting. Additional supports for patients that can be provided includes easily accessible education and reference materials for patients, caregivers, community care workers and pharmacists. Based on his experience, further opportunities for improvement noted by Mr. Choate some of which included:

- Utilizing existing and new technology for Remote Patient Monitoring (RPM);
- Utilizing monitored drug dispensers or reminder programs;
- Establishing well defined communication check points with the patient's care team to identify and manage adverse events;
- Develop more community based programs as they are more accessible.

Jodeme Goldhar

Jodeme Goldhar, Lead, Health System Integration for Complex Populations and Primary Care at the Toronto Central Community Care Access Centre (CCAC), began by describing the current context in home and community care in Toronto where demands on support at home and in the community are increasing due to the number of people seeking assistance to remain at home and the complexity of their needs. Ms. Goldhar further described the work of the Toronto Central CCAC to 'knit' the system together to wrap care around the client and their family and/or caregivers. Functionally integrating at the point-of-care through inter-sectorial, inter-organizational and inter-professional teams is one way to support populations with complex needs at home in their communities, utilizing existing resources in the system. This 'ONE TEAM' approach ensures seamless care and a focus on safety for

clients and their families/caregivers by coordinating care around their needs every day.

Janet Graham
Janet Graham, from The Ottawa Hospital, provided the renal perspective with providing care at home and in the community, particularly in remote areas for people who have chronic kidney disease. The renal community has been providing care at home for more than 30 years. Through the experience of providing care to complex patients the renal community has learned that providing care at home is an arguably superior model that provides improved quality of care. Currently, there are over 10,000 patients within Ontario that are receiving life sustaining dialysis care, of which 22% receive this care at home. Now through 30 years of experience and through research, there is evidence that there are many benefits to providing dialysis at home. Patients have more flexibility and are in better health and they retain control. For high risk procedures, the Ontario Renal Network has been able to weigh the risks and compare them to the absolute benefits and connect patients to outreach teams in the community. Patients are provided with extensive information and education but all also connected to a care team to provide them with a sense of security for questions and support should issues arise. Patients receiving care at home are also supported through partnerships that enable patients to be connected to a community care team through each of the 14 LHINs. Other innovative solutions have been considered including mobile technology.

Dr. Nevina Kishun (PharmD)
Dr. Nevina Kishun, Senior Manager - Clinical Excellence with the Shoppers Drug Mart Patient Contact Centre, provided the perspective of a community pharmacist and the interaction with people to support patient safety at home in the community. Dr. Kishun began her presentation by highlighting the opportunities to engage community pharmacists to improve patient safety. There are 3,400 community pharmacies in Ontario allowing pharmacists to be the most accessible healthcare professionals to the public. Pharmacists are frequently consulted regarding over the counter medications, however pharmacists are not always informed of the many impacts of these medications may have on cancer patients. Pharmacists can successfully increase communication between the patient and the medical oncologist in the event that patients experience adverse events as a result of their treatment and are looking for over the counter treatments to help them manage these adverse effects.

Several strategies can be used that involve the community pharmacist to improve the safety of patients taking oral chemotherapy at home. Some strategies include:

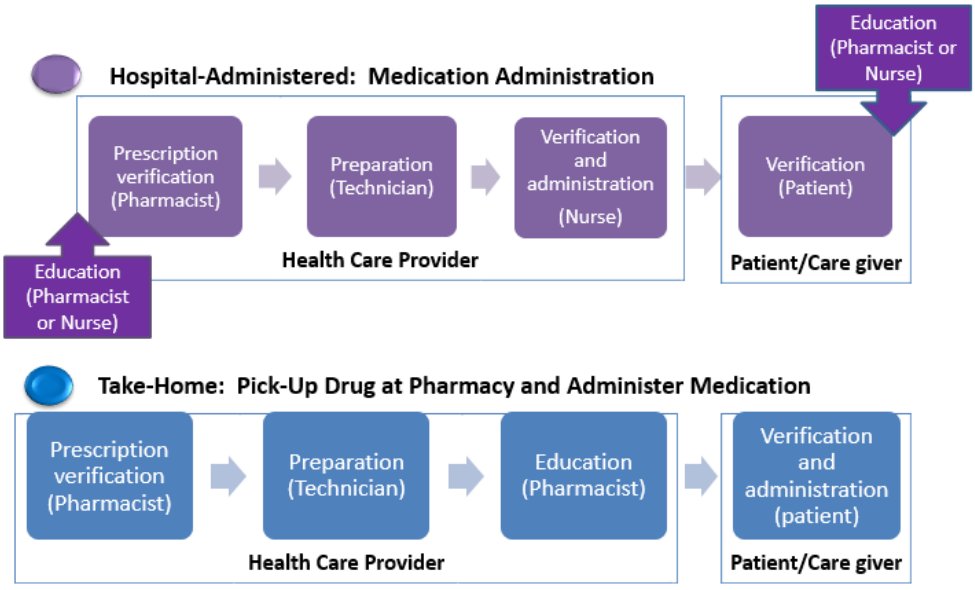
- Pre-printed orders so chemotherapy can be reviewed for clinical appropriateness, including off-label uses and unusual dosing;
- Disseminating knowledge around locating current and standardized resources;
- Clear labeling of drugs including intended start date, duration of treatment and intended stop date

- Information on safe handling, storage and disposal procedures of drugs for patients, family members and friends.

Dr. Kathy Vu (PharmD)

Dr. Vu, Clinical Lead for Systemic Treatment Safety with CCO, provided a provincial perspective on safety at home for cancer patients, particularly patients taking oral chemotherapy. Dr Vu began her presentation by providing an overview of the major steps that processes that patients goes through when receiving chemotherapy. She presented two scenarios – patients receiving treatment in hospital versus those receiving take home therapies. The greatest safety challenges for patients on oral chemotherapy was identified in the administration and dispensing process, particularly in the community setting where prescription verification is not standardized and can be hindered by the omission of key information on the prescription. Safe handling practices during the preparation process as well as the lack of an independent double check are other safety concerns. Patient education, which may assist with proper self-administration of oral chemotherapy in the home, may be incomplete or varied thus contributing to further potential errors. .

Figure 6: *Safety concerns for cancer patients on oral chemotherapy*



Source: Vu (2014). "*Supporting patients at home: Challenges and solutions for strengthening patient safety in the home and community*." Slide 3. Toronto, November 19, 2014.

Dr. Vu also stressed the importance of looking at the monitoring of toxicities as an important part of patient safety in the home and community. Monitoring should be conducted from both a toxicity as well as an adherence perspective. Cancer Care Ontario has undertaken several initiatives to mitigate the challenges faced in ensuring that care is safe in the home and community. For instance, Dr. Vu highlighted several initiatives designed to standardize patient education materials so that the content reflects best practices. Dr. Vu concluded by noting that there is still a lot of work in this area that can be done in terms of toxicity management.

Using guidelines, standardized tools and technology in order to engage community partners to help in symptom and toxicity management can be an effective strategy to improve patient safety initiatives.

10. Afternoon Breakout Group Discussion

A second breakout group discussion was scheduled following the afternoon sessions at the event. Similar to the morning breakout group discussion, attendees were assigned to a breakout group with a diverse range of expertise and were asked to consider the following two (2) questions:

- What information and supports are needed to ensure safe care at home and in the community for cancer patients, specifically for those using oral chemotherapy?
- At a system-level, how can we strengthen reporting of incidents and near misses in the home and community to enhance patient safety in the cancer system?

Groups were given 30 minutes for discussion followed by a report back on one "big idea" that was discussed in each of the 10 groups and are captured below.

'Big ideas' from breakout group discussions:

- Increase focus on system integration across the continuum of care and providing psychosocial supports for patients
- Create a system wide and standard approach to discharging patient and points of transfer for patients taking chemotherapy at home
- Build a centralized reporting structure to strengthen reporting in the home and community
- Create a partnership with the college of pharmacists, similar to the partnership between CCO and the CPSO.
- Empower patients to report incidents that may occur at home or in the community.
- Leverage innovative technologies to increase support for and monitoring of patients receiving care at home and in the community.
- Create tools that facilitate specialized supports that are easily accessible.
- Increase research in the area of safety in the home and community;
- Create a central location that stores an inventory of drugs being taken by patients.
- Have clear definitions for incidents and near misses and ensure that data being collected on these events are analyzed and used for quality improvement.

11. Cancer Care Ontario's commitment to patient safety in cancer care

Dr. Michael Sherar, President and CEO of Cancer Care Ontario, began by noting some of the transformational changes that the province has made during the last 10 years in creating a culture of safety and quality improvement in the cancer system. Some of the province's successes in creating this culture have included the introduction of incident reporting, the implementation of Computerized Physician Order Entry (CPOE), low colonoscopy perforation rates and the introduction of multidisciplinary case conferences to have a shared review of plans for patient treatment.

The discussions and presentations at today's event have highlighted the need for Ontario to develop a broader and more comprehensive approach to safety in the cancer system, both inside and outside the hospital setting. Dr. Sherar described safety as the most important dimension of quality, but that it currently ranks lower on the agenda by our healthcare community. We need to learn from other industries such as aviation who prioritize safety first above all else. He attributed this difference in approaches to safety to culture. To address this gap, Dr. Sherar emphasized the need for the province to make a concerted effort to improve safety in cancer care across Ontario by prioritizing safety within the provincial plan, improving necessary data and information, and to engaging leaders and front line staff in reporting. He highlighted the need to focus on a proactive and predictive approach to understanding the risks for safety in the system, as well as in generating evidence to create cultural change. Dr. Sherar expressed the need to engage patients and families in this work and continue to have them as partners in forming the future state. Successes will need to be celebrated in this new model to support the transformation.

Dr. Sherar shared that safety will be one of the core themes within the soon-to-be released Ontario Cancer Plan VI, the strategy that will guide Cancer Care Ontario's priorities from 2015-2019. He closed by noting that the markers of our joint success in this endeavor will be the prioritization, measurement and celebration of safety across the province, with the help of Cancer Care Ontario and the Cancer Quality Council of Ontario.

12. CQCO's commitment to patient safety in the cancer system

Ms. Virginia McLaughlin, Chair of the Cancer Quality Council of Ontario, expressed her thanks to the speakers, facilitators, panelists and steering committee for guiding the content of the event. She also thanked Dr. Sherar and CCO for their commitment and support of the work of the CQCO. She stated that the CQCO pledged to augment the patient safety data within the Cancer System Quality Index and to continue to hold CCO accountable to facilitating the creation of a culture of safety across the province. Ms. McLaughlin thanked the attendees for participating in the day.

13. APPENDICES

Agenda

7:30 a.m.	**REGISTRATION AND CONTINENTAL BREAKFAST**
8:30 a.m.	**WELCOME** What are we talking about? The need to address patient safety across the continuum of care to ensure the delivery of safe care to all cancer patients in Ontario ***Dawn Powell**, Chair, Patient and Family Oncology Partnership Council, Thunder Bay Regional Cancer Centre, Thunder Bay*
8:40 a.m.	**INTRODUCTIONS AND OVERVIEW** Patient safety in the cancer system: Building a culture of safety across the system to improve the patient's experience and avoid adverse outcomes ***Virginia McLaughlin**, Chair, Cancer Quality Council of Ontario, Toronto*
8:55 a.m.	**PATIENT SAFETY IN ONTARIO** People Matter ***Hugh MacLeod**, Chief Executive Officer, Canadian Patient Safety Institute, Edmonton*
9:15 a.m.	**SYSTEM LEVEL STRATEGY PLANNING FOR PATIENT SAFETY** Scotland's system-wide patient safety improvement journey: Sharing lessons learnt from the Scottish experience ***Jane Murkin**, Head of Patient Safety and Improvement, NHS Lanarkshire, NHS Scotland, Bothwell, Scotland*
9:45 a.m.	**FACILITATED DISCUSSION** Facilitator: ***Dr. Darren Larsen**, Vice Chair, Cancer Quality Council of Ontario, Toronto*
10:00 a.m.	**MORNING BREAK**
	CHANGING CULTURE AT THE SYSTEM LEVEL
10:15 a.m.	Patient Safety and Culture: A 30,000 Foot View - Lessons Learned from the Evolution of Safety in Aviation ***David Deveau**, Vice President, Safety, Quality and Environment, Jazz Aviation LP, Halifax*
10:45 a.m.	System-level enablers for culture change: Mindfully creating culture to improve the safety of care ***Sallie Weaver**, Assistant Professor, Department of Anesthesiology and Critical Care Medicine, Armstrong Institute for Patient Safety and Quality, John's Hopkins University, Baltimore, United States*

11:15 a.m. **FACILITATED DISCUSSION**
Facilitator: ***Dr. Joshua Tepper****, President and Chief Executive Officer, Health Quality Ontario, Toronto*

11:30 a.m. The impact of culture on the implementation and sustainability of peer review programs in radiation therapy *(including Q&A)*

Facilitator: ***Dr. Craig McFadyen****, Regional Vice President, Carlo Fidani Regional Cancer Centre, Mississauga*
Dr. Woodrow Wells*, Physician Lead, Radiation Oncology, Southlake Regional Cancer Centre, Newmarket*
Dr. Jason Pantarotto*, Chair, Division of Radiation Oncology, The Ottawa Hospital Regional Cancer Centre, Ottawa*

11:55 a.m. **MORNING BREAKOUT SESSION**

12:20 p.m. **REPORT BACK**

12:30 p.m. **LUNCH**

IMPROVING PATIENT SAFETY IN CANCER CARE

1:15 p.m. ***The Quality Management Partnership: a new partnership to improve patient safety and improve quality of care in Ontario***
Lynn Guerriero*, Managing Director, Cancer Screening, Cancer Care Ontario*

Wade Hillier*, Director, Quality Management Division, College of Physicians and Surgeons of Ontario*

2:00 p.m. **RAPID ROUND SESSION**
Systematic considerations of patient safety in planning: Learning systems for embedding safety into service delivery
(Rapid round presentations to be followed by a Q&A)

Facilitator: ***Virginia McLaughlin****, Chair, Cancer Quality Council of Ontario, Toronto*
Debbie Barnard*, Chief Quality and Safety Officer, Health Sciences North, Sudbury*
Gaylene Medlam*, Supervisor, Radiation Therapy, Carlo Fidani Peel Regional Cancer Centre, Mississauga*
Roger Cheng*, Project Leader, Institute for Safe Medication Practices Canada, Toronto*

2:30 p.m. **AFTERNOON BREAK**

PATIENT SAFETY IN THE HOME AND COMMUNITY

2:45 p.m. **PANEL AND AUDIENCE DISCUSSION**
Supporting patients at home: Challenges and solutions for strengthening patient safety in the home and community *including Q&A*

Facilitator: ***Joanne MacPhail****, Co-Chair, Patient and Family Advisory Council, Cancer Care Ontario, Toronto*
Panel speakers:
Andrew Choate*, Member, CCO Patient and Family Advisory Council, Garden Hill*
Jodeme Goldhar*, Lead, Health System Integration for Complex Populations and Primary Care, Toronto Central Community Care Access Centre, Toronto*
Brenda Lynn*, Director, Oncology, Renal and Telemedicine Programs, Sault Area Hospital and Regional Director, Ontario Renal Network, Sault Area*
Nevina Kishun*, Senior Manager, Clinical Excellence – Patient Contact Centre, Shoppers Drug Mart, Mississauga*
Kathy Vu, *Clinical Lead, Systemic Treatment Safety Initiative, Cancer Care Ontario, Toronto*

3:35 p.m. **AFTERNOON BREAKOUT SESSION**

4:05 p.m. **REPORT BACK**

4:15 p.m. **COMMITMENT FROM CANCER CARE ONTARIO**
Michael Sherar, President and Chief Executive Officer, Cancer Care Ontario, Toronto

4:25 p.m. **CLOSING REMARKS**
Virginia McLaughlin, Chair, Cancer Quality Council of Ontario, Toronto

2014 CQCO Signature Event Steering Committee

With acknowledgement and gratitude to the members of our CQCO Signature Event Steering Committee for their guidance and support in planning this event:

Virginia McLaughlin (Chair), Chaim Bell, Lillian Clarke, Ruthe Anne Conyngham, Anthony Easty, Martin Kabat, Darren Larsen, Joanne MacPhail, Hugh McLeod, Robin McLeod, Ralph Meyer, Dawn Powell, Linda Rabeneck, Joshua Tepper.

Cancer Quality Council of Ontario Secretariat

Rebecca Comrie, Director
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CQCO's Eleventh Annual Signature Event:

Strengthening the Culture of Patient Safety in Ontario's Cancer System for Improved Patient Care Speakers Biographies

(In order of presentation)

Virginia McLaughlin, Chair, Cancer Quality Council of Ontario

Virginia McLaughlin has been a member of CQCO since 2011 and has been serving as the Council Chair since 2013. She currently serves as a volunteer trustee on the Boards of trustees of the University of Guelph and the Canadian Museum of Science and Technology Corporation. In addition she is Honorary Lieutenant-Colonel of the 25 (Toronto) Field Ambulance. She is a past Chair of the Board of Directors, Sunnybrook Health Sciences Centre and a past chair of the Governance Leadership Council of the Ontario Hospital Association.

Prior to becoming a member of the Sunnybrook & Women's Board of Directors, Ms. McLaughlin was a member of the Board of Trustees, York Central Hospital (1985-1997) and Chair of the Board from 1995-97. She chaired the GTA/905 Healthcare Alliance from 1995-1998 and the York Region Tri-Hospital group from 1995-97. Ms. McLaughlin has also participated in governance for the Ontario Hospital Association as a member of the Regional Council Executive Committee for Region 3 (Toronto, York, Peel and Durham) 1998-2008, as chair of the RCEC 2000-2002, member of the OHA board of Directors 2000-2002 and chair of the OHA Advocacy Committee (2001-2002) and from 2004 until November 2007 was the Chair of the Ontario Hospital Association Governance Leadership Council. Other recent volunteer commitments include Chair of the Board of Trustees of the University of Trinity College (2003-2005; member since 1999), Chair of Finance Committee (2000-2003) and member of Nominating Committee for the Provost (2001).

During the 1980's and early 1990's Ms. McLaughlin served as a volunteer member of the Toronto Symphony Board, Toronto Symphony Volunteer Committee and Junior Women's Committee and as a member of the Country Day School Board and Chair of the Junior School Curriculum Committee. In private life, Ms. McLaughlin is President of Helmhorst

Investments Limited and Ferdinand Holdings Limited. She is married and has two adult children and three grandchildren.

Dr. Darren Larsen, MD, Vice Chair, Cancer Quality Council of Ontario

Over his 24 years as a comprehensive care Family Physician Darren has been involved in many provincial and national Health IT, Quality and Leadership initiatives. He has advised and acted in this space for OntarioMD, the Ontario Medical Association, and the Canadian Medical Association, and serves on e-health and quality committees for Health Quality Ontario, eHealth Ontario and Cancer Care Ontario. He is currently vice chair of the Cancer Quality Council of Ontario and works for the OMA as its Chief Medical Information Officer.

Darren obtained his BSc at the University of Alberta, MD at the University of Calgary and did residency at the University of Ottawa. He holds a Masters Certificate in Physician Leadership from York University's Schulich School of Executive Management. His happy place is on his snowboard, with his teenage kids, on the top of any mountain he can find.

Dawn M. Powell, Chair, Patient and Family Oncology Partnership Council (unable to attend the event)

Dawn Powell is a 7-year cancer survivor. Because of the many challenges she encountered through treatment and beyond, she believes that her

involvement as a PFA will make the system better for future cancer patients. She is actively involved in the Northwest Regional Cancer Centre offering a patient's perspective on numerous committees including the PFCC Leadership Council. Her vision of Cancer Care in 2014 formed the core for the Regional Cancer Care Plan III. She is actively involved as a PFA with the Thunder Bay Regional Research Institute. She also chairs a unique group of cancer patients and survivors called the Cancer Partnership who work with the Executive and Management of Cancer Care Northwest to improve the cancer journey for all involved. She is active on several committees within Cancer Care Ontario and is member of the Cancer Quality Council of Ontario.

Professionally, she is an accredited member of the Appraisal Institute of Canada and holds a MSC from the University of St. Thomas in Minneapolis. She has been appraising real property since 1978 and is the President of Powell Appraisals, specializing in commercial, institutional and industrial real property valuation since 1986. She enjoys motorcycling, photography and the great outdoors. She has been married to Eric for 28 years and they look forward many happy, healthy years together.

Hugh MacLeod, Chief Executive Officer, Canadian Patient Safety Institute (CPSI)

Prior to joining CPSI in 2010, Hugh held senior positions with the Government of Ontario as associate deputy minister of the climate change secretariat and associate deputy minister for the Ontario Ministry of Health and Long-Term Care. During his four years with the ministry, he was also the executive lead of the Premier's Health Results Team, responsible for a provincial surgical wait time strategy, a provincial primary care strategy, and the creation of local health integration networks.

Hugh has also held a number of senior executive positions in British Columbia, including senior vice-president of Vancouver Coastal Health and senior vice-president of the Health Employers Association of British Columbia.

Hugh's professional activities include serving as senior fellow at the University of Toronto, Rotman School of Management; adjunct professor at the University of British Columbia, Faculty of Medicine; associate faculty at Royal Roads University, Victoria, Faculty of Social and Applied Science; and adjunct professor at Griffith University Business School in Brisbane Australia.

Jane Murkin, Head of Patient Safety and Improvement, NHS Lanarkshire, NHS Scotland

Jane is an experienced change leader with extensive experience in senior leadership roles, where she has led on the design and implementation of national and local improvement programmes to transform health and care. These have included:

- Scottish Patient Safety Programme
- Reducing Harm Collaborative
- Person centered health and care
- NHS Scotland's Quality Improvement Hub
- Whole system patient flow
- Planned Care

Jane joined NHS Lanarkshire in February 2014 with a wealth of national experience having worked in the Scottish Government for several years and also worked as a Professional Advisor for the Chief Nursing Officer on Quality Improvement. She has held several senior roles across the NHS in a range of organisations at an operational, strategic and national level, with over twenty five years' experience in the NHS. She is a nurse and midwife by background, retaining her professional qualification as a Registered General Nurse.

Jane has a strong sense of direction, achieving outcomes and capable of supporting others in achieving their goals by using a wide range of leadership styles and influencing skills to motivate, engage and secure commitment and build strong collaborative working relationships.

She has spent many years teaching, coaching and facilitating improvement to create an open, supportive and positive culture that maximizes the potential of staff and develop effective teams through facilitating a culture of inclusiveness, integration and multidisciplinary working to drive a continuous quality improvement and person centered health service. She is a recent graduate of the Kings Fund Athena Programme (Women in Executive Leadership Programme).

David T.Deveau, P.Eng., MBA - Vice President Safety, Quality & Environment, Jazz Aviation LP

David is a professional engineer with 18 years aviation management experience in addition to five years public sector executive experience with the Nova Scotia Department of Justice. His career has centered around process improvement, quality management and aviation safety, including workplace safety. He has

also been instrumental in designing, implementing and managing organizational strategic change.

Vice President of Safety Quality and Environment for Jazz Aviation LP (Chorus Aviation), David is responsible for the design, operation and effectiveness of the safety management system (SMS), Quality Management System (QMS) and Environmental Management System (EMS) of Canada's busiest airline, as measured by the number of daily domestic flights.

David is current chair of both the Safety Subcommittee of the National Airlines Council of Canada (NACC) and of the Safety Council of the USA-based Regional Airline Association (RAA). He also serves as the aviation industry representative on the recently formed Federal Occupational Health and Safety Advisory Committee and is a member of the Board of Directors of Parachute Canada (injury prevention not-for-profit). He presents frequently at aviation safety forums across North America and abroad and is an eager champion for evidence-based risk management and just culture as a necessary backdrop to improving safety performance.

David holds a bachelor's degree in industrial engineering, a bachelors of environmental design studies and a masters in business administration. A member of the Flight Safety Foundation and the Institute of Corporate Directors, he makes his home near Halifax, Nova Scotia.

Dr. Sallie J. Weaver, PhD, Assistant Professor, Department of Anesthesiology and Critical Care Medicine, Armstrong Institute for Patient Safety and Quality, John's Hopkins University

Sallie J. Weaver, is an Industrial-Organizational Psychologist and Assistant Professor in the Department of Anesthesiology and Critical Care Medicine at the Johns Hopkins School of Medicine. Dr. Weaver holds an appointment with the Armstrong Institute for Patient Safety and Quality where her stream of research focuses on organizational factors that influence team performance and interventions designed to optimize patient safety and quality of care. This includes a particular focus organizational culture, multi-team systems, and leadership. Dr. Weaver also currently serves as a Faculty Advisor for Training and Development within the Armstrong Institute and is supporting efforts to build capacity in patient safety and quality leadership across Johns Hopkins Medicine. Her work appears in peer reviewed outlets including the Annals of Internal

Medicine, Academic Medicine, The Joint Commission Journal on Quality & Patient Safety, and the Journal of Continuing Education in the Health Professions.

Dr. Craig McFadyen, MD, Regional Vice President, Cancer Care Ontario for the Mississauga, Halton & Central West Regional Cancer Program, Chief & Medical Director, Oncology Program, Trillium Health Partners

 In addition to managing the oncology program across Trillium Health Partners' three sites (Credit Valley Hospital, Mississauga Hospital, and Queensway Health Centre), Dr. McFadyen oversees regional oncology services for the three additional partners in care for the Mississauga Halton/Central West Regional Cancer Program - Halton Healthcare Services, Headwaters Healthcare Centre, and William Osler Health System. Dr. McFadyen also manages a practice specializing in breast cancer at the Credit Valley Hospital site.

Prior to overseeing the Mississauga Halton/Central West Regional Cancer Program, Dr. McFadyen was the Vice President of Regional Cancer Services for the Waterloo Wellington Regional Cancer Program and Vice President at Grand River Hospital. He was instrumental in leading the Oncology Wait Time Initiative and the establishment of Rapid Diagnostic Units in Waterloo Wellington.

Dr. McFadyen received his MD in 1982 from the University of Calgary, and his surgical fellowship training in Toronto before starting his practice in Kitchener-Waterloo. He holds a Masters of Health Care Management from Harvard University.

Dr. Woodrow Wells, MD, Physician Lead, Radiation Oncology, Southlake Regional Cancer Centre

Dr. Woody Wells is the Physician Lead for the Radiation Medicine Program at the Stronach Regional Cancer Centre, at Southlake Regional Health Centre in Newmarket, Ontario, since its opening in March 2010. Prior to his career he was a Radiation Oncologist at the Princess Margaret Hospital in Toronto. He is an Assistant Professor at the University of Toronto.

Dr. Wells' clinical interests are in skin cancer, malignant lymphomas, and breast cancer. His scholarly pursuits have been in medical education, both undergraduate and postgraduate medicine, and also in the realm of inter-professional education and teamwork. He has been a member of the Board of Medical Assessors and the Board of Examiners at the University of Toronto. He was also a ten year member and co-chair of the Radiation Oncology Specialty Committee of the Royal College until 2010. At the Stronach Centre his particular interest is in the culture of the inter-disciplinary workplace as it relates to quality and safety.

Dr. Jason Pantarotto, Chair, Division of Radiation Oncology, The Ottawa Hospital Regional Cancer Centre

Dr. Pantarotto is the chair of the University of Ottawa Division of Radiation Oncology and Head of the Radiation Medicine Program at The Ottawa Hospital in Ottawa, Canada. He

received his engineering degree from Queen's University, Kingston, Ontario and his medical degree from Western University, London, Ontario. He completed a residency in radiation oncology at the University of Ottawa and subsequently spent one year in Amsterdam at the VU University Medical Centre performing a research fellowship in image guided 4-Dimensional radiotherapy. He joined The Ottawa Hospital as staff radiation oncologist in 2008.

He is an active participant in the Cancer Care Ontario Program in Evidence Based Medicine. Research interests include ablative radiotherapy for chest and abdominal tumours, advanced radiotherapy techniques for moving targets and factors related to process flow within radiation medicine.

Lynn Guerriero, **Managing Director, Cancer Screening, Cancer Care Ontario**

Lynn Guerriero is the Managing Director of Cancer Screening at Cancer Care Ontario (CCO).

Lynn joined CCO in 2008 and has held increasingly senior roles. She was responsible for executing on Ontario's information strategies related to surgery, diagnostic imaging, emergency room and alternate level of care wait times. Most recently, she completed the integration of Ontario's organized screening programs for breast, colorectal and cervical cancer. Lynn was also recently appointed the CCO lead for the newly formed Quality Management Partnership with the College of Physicians and Surgeons of Ontario.

Prior to her joining CCO, Lynn had held leadership roles across the health sector. She is a clinician by background, holding a Bachelor's degree in Occupational Therapy. She also has a Master's degree in Health Science, Health Administration from the University of Toronto. She is a Certified Health Executive with the Canadian College of Health Leaders.

While at the University of Toronto, Lynn was the recipient of the Harold Livergant Scholarship and the Robert Wood Johnson Award. In 2009, she received the Canadian Project Excellence Award for Project Leadership.

Wade Hillier, Director, Quality Management Division, College of Physicians and Surgeons of Ontario

Wade Hillier is Director of the Quality Management Division of the College of Physicians and Surgeons of Ontario. In this role, he oversees strategy and operations for three operational units: Practice Assessment & Enhancement; Applications & Credentials and Membership Services, Corporations & Physician Register.

Since joining the College in 2001 Wade has supported and led a variety of projects and initiatives with the ultimate goal of improving safety, consistency and access to patient-centred care clinical practice guidelines, quality assurance and out-of-hospital premises program development, increasing the annual number of physician assessments, enhancing the CPSO's oversight role in opioid prescribing, implementation of new pathways for physician registration in Ontario and in the work conducted by the Quality Management Partnership (QMP) of the College and Cancer Care Ontario.

Debbie Barnard, MSc, CPHQ, Chief Quality and Patient Safety Officer, Health Sciences North

Debbie Barnard was appointed as Director, Quality and Patient Safety for Health Sciences North in August 2011 and named Chief, Quality and Patient Safety Officer in December 2013. She brings over three decades of experience in the healthcare industry to HSN.

For the past 15 years, she has successfully pursued her passion for the "improvement of the quality of the provision of healthcare services to the patients and families" in a variety of national, provincial and organization-wide positions including Executive Director, Clinical Quality Support, Alberta Health Services; National Project Manager with the Canadian Patient Safety Institute (CPSI); Surveyor for The Joint Commission, (US Based Healthcare Accreditation Body) and Performance Improvement Director, US Based DeKalb Regional Healthcare System.

Her educational background includes; a General Nursing Diploma, a Certificate in Advance Nursing Education (Hons), a Bachelor of Arts in Applied Behavioural Sciences, and a Master of Science in Human Resource Management and Development. Debbie is also a designated Certified Professional in Healthcare Quality (CPHQ).

Gaylene Medlam, Supervisor, Radiation Therapy, Carlo Fidani Peel Regional Cancer Centre

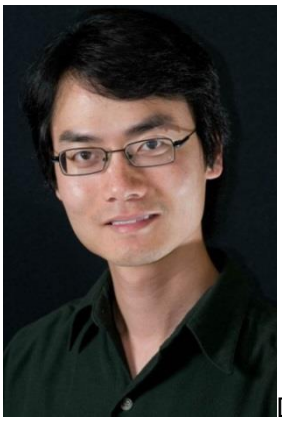
Gaylene Medlam is a Supervisor in Radiation Therapy at the Carlo Fidani Peel Regional Cancer Centre in Ontario Canada, and a member of the Canadian Association of Medical Radiation Technologists. Gaylene obtained her diploma in Therapeutic Radiography and B.Sc. in Radiation Therapy from the UK.

While working at Princess Margaret Hospital in Toronto as a Therapist she became involved in incident reporting and Quality Management, she became the Practice Lead for Quality and Patient Safety until moving to PRCC in 2006. As well as being a Supervisor, Gaylene chairs the Radiation Program QA committee and is the lead for incident reporting within the program.

In 2005 Gaylene developed an online course entitled Quality in Healthcare as a selective offered as part of the joint degree program for Medical Radiation Sciences program at the Michener Institute and University of Toronto. In 2013 this course became part of the main curriculum.

Gaylene has presented at several major conferences on the topic of quality and safety in radiation oncology and has contributed to several published articles. In 2014 she became co-chair of the Radiation Incident Safety Committee (RISC) along with Crystal Angers, who is a Medical Physicist at the Ottawa Hospital Cancer Centre.

Dr. Roger Cheng, RPh, BScPhm, PharmD, Project Leader, Institute for Safe Medication Practices Canada

 Dr. Cheng joined ISMP Canada in 2007 as an analyst. His current responsibilities as a project leader include conducting individual and multi-incident analysis from the medication incidents in the ISMP Canada Medication incident database.

Dr. Cheng holds a Bachelor of Science in Pharmacy degree (1999) and a Doctor of Pharmacy degree (2003) from the University of Toronto. Roger has worked in both community and hospital pharmacy settings, including staff pharmacist positions at Princess Margaret Hospital and York Central Hospital.

Joanne MacPhail, Co-Chair of Patient Family Advisory Council and Breast Cancer Survivor

 Joanne was elected as Co-Chair in May 2011 for the first PFAC (Patient Family Advisory Council), which originally pioneered in May 2011 to act as an internal advisory group for CCO on strategies to improve the patient experience. Over the past few years it has evolved with an expanded mandate to support the Corporate Strategy on strategies to partner with patients to advance patient-centered care. As Joanne's first experience in working with CCO (Cancer Care Ontario), she has found it a very worthwhile experience and has enjoyed partnering with the staff members of CCO to work towards improving the patient experience.

Joanne was Human Resource Manager, with Hercules Tire Co. of Canada Inc. for the past 25 years and most recently retired from this position. During her career, Joanne has

completed a number of courses in all aspects of human resources, from health and safety to recruiting.

Joanne is a metastatic Breast Cancer survivor, which she has journeyed with twice over the past 19 years. Joanne's journey began in 1993/94 and then again in 2008. She has endured a number of surgical operations, lost both breasts and has experienced both chemotherapy and radiation.

In the face of Cancer, Joanne is still here and enjoying life with her wonderful husband, constant support and care giver, John, for 42 years and their three wonderful children, Melissa, Andrew and Heather.

Andrew Choate, Member, CCO Patient and Family Advisory Council

Andrew Choate is a volunteer member of the CCO, Patient and Family Advisory Council. He was diagnosed with an incurable, rare form of Non-Hodgkin's Lymphoma, Waldenstrom's Macroglobulinemia and he is managing Type 2 Diabetes. Andrew prefers not to be defined by his co-morbities and chooses to assist in bringing patient centeredness to the forefront in Ontario's Health Care System.

Even in retirement, Andrew approaches many of life's problems from a systems perspective. He spent in excess of 35 years in the nuclear power generation industry implementing projects and managing various IT enterprise systems.

Andrew supports a Health Care Model that moves cancer treatment into the patient's home.

Jodeme Goldhar, MSW, RSW, MHSc, Lead, Health System Integration for Complex Populations and Primary Care, Toronto Central Community Access Centre

Jodeme Goldhar has held clinical and strategic leadership positions in health care for over twenty years. With Masters Degrees in Social Work as well as Health Science, Policy, Management and Evaluation, she has been a key innovator and leader in healthcare strategy that has resulted in key changes in care delivery and methodology. In 2010, Jodeme joined the Toronto Central CCAC team as the Lead for Health System Integration for Complex Populations and Primary Care. As a key player in the formation of the Integrated Client Care Project (ICCP), she has seen this initiative recognized by the Canadian Home Care Association (CHCA) as a national High Impact Practice.

An innovative leader and adept consensus-builder, Jodeme has also been recognized by her peers as a Canadian Woman Changing Healthcare. She is continually inspired to work towards delivering the highest level of client care possible. In 2012, her role expanded as the Planning Lead for Health Links, helping to deliver the local primary care integration strategy and inform the provincial work on primary care integration. Jodeme is President, Institute for Health Policy, Management and Evaluation (IHPME), Society of Graduates and Adjunct Lecturer at the University of Toronto. She is currently Principal Investigator for research projects focused on integrated care at the Baycrest Centre, the Li Ka Shing Research Centre at St. Michael's Hospital, and York University. She is also Co-Principal Investigator on a BRIDGES-funded project based at Mt. Sinai Hospital.

Brenda J. Lynn, Director, Oncology, Renal and Telemedicine Programs, Sault Area Hospital and Regional Director

Brenda Lynn holds a strong progressive clinical and administrative background. She has worked in the field of HealthCare Administration for the past 30 years as an innovative and strategic professional. Brenda is currently the Clinical Director for the Algoma District Cancer Program (ADCP), the Algoma Regional Renal Program and the Telehealth Program within Sault Area Hospital in Sault Ste. Marie, Ontario. She is also the NE Regional Director for the Ontario Renal Network.

Brenda chairs the NE Palliative Care Algoma committee and the ADCP Patient Family Advisory Council. As well, she sits on the NE Diabetes Advisory Council. Brenda completed her Masters of Science with a major in Health Administration and holds professional affiliations with the Ontario College and Nurses, RNAO, CANO and CANNT.

Brenda can be described by her colleagues as inspiring teams, cultivating relationships and strategic execution to affect measurable and progressive change. She is accomplished in building and maximizing performance within a dynamic team environment. In her spare time, Brenda can be found traveling to Victoria, B.C. to spend time with her grandchildren.

Dr. Nevina Kishun, PharmD, Senior Manager, Clinical Excellence – Patient Contact Centre, Shoppers Drug Mart

Dr. Nevina Kishun was part of Cancer Care Ontario's Systemic Cancer Treatment and Community Pharmacy working group for the Systemic Treatment Provincial Plan. She started her pharmacy career as a community pharmacist with Shoppers Drug Mart, progressing to an Associate Owner. She then moved into Shoppers Drug Mart Specialty Health Network where she managed the pharmacy that provides high cost,

specialty medications. Dr. Kishun currently oversees Clinical Excellence in the Patient Contact Centre for Shoppers Drug Mart where she is committed to advancing the professional practice of pharmacy.

Dr. Kishun holds a Doctor of Pharmacy from the University of Florida, a Bachelor of Science in Pharmacy from the University of Saskatchewan and a Bachelor of Science in Pharmaceutical Chemistry from the University of Guelph.

Dr. Kathy Vu, PharmD, Clinical Lead, Systemic Treatment Safety Initiative, Cancer Care Ontario

Dr. Vu is the Clinical Lead for Safety Initiatives in the Systemic Treatment Program at Cancer Care Ontario. She is involved with provincial initiatives to improve the safe delivery of chemotherapy, including incident reporting and the safe dispensing of oral chemotherapy. Dr. Vu graduated from the University of Toronto where she obtained her Bachelor of Science degree in Pharmacy in 1999. She later went on to complete a hospital residency and her Doctor of Pharmacy degree.

Prior to joining Cancer Care Ontario, Dr. Vu was a Clinical Pharmacy Practitioner at St. Michael's Hospital for 12 years. She practiced is in the area of Hematology and Oncology where she provided care to cancer patients with complex medication needs. Her areas of specialization include the management of pain, nausea and vomiting and thromboembolism. She also managed an ambulatory anticoagulation clinic where she provided INR monitoring, warfarin dosing and education to patients under her care.

Dr. Vu is also involved with the Faculty of Pharmacy at the University of Toronto. She is a lecturer, facilitator and teaching associate for the Doctor of Pharmacy program. In addition, Dr. Vu is also actively involved with the Continuing Professional Development Program as a course coordinator for the International Pharmacy Program and speaker for numerous events.

Dr. Michael Sherar, PhD, President and Chief Executive Officer, Cancer Care Ontario

 Dr. Michael Sherar is President and CEO of Cancer Care Ontario. From 2006 to 2011, he was the provincial agency's Vice-President, Planning and Regional Programs, leading the development of Regional Cancer Programs, including capital planning for cancer services across the province. In this role, he led the development of the *Ontario Cancer Plan 2011-2015*.
Dr. Sherar is Professor of Medical Biophysics at the University of Toronto and Affiliate Scientist Techna Institute University Health Network where he carries out research and development of minimally invasive thermal therapy technologies for cancer including radiofrequency ablation.

In 2001, he was selected as one of *Canada's Top 40 under 40* for achievements in leadership. He was previously Regional Vice President, Cancer Services, London for Cancer Care Ontario and Vice President, London Regional Cancer Program (LRCP), London Health Sciences Centre (LHSC).

Dr. Sherar received a BA in Physics from Oxford University in 1985 and his PhD in Medical Biophysics from University of Toronto in 1989.

CQCO's Eleventh Annual Signature Event: Strengthening the Culture of Patient Safety in Ontario's Cancer System for Improved Patient Care Event Attendees

First name	Last name	Organization
Rebecca	Anas	Cancer Quality Council of Ontario Secretariat
Crystal	Angers	The Ottawa Hospital
Jessica	Arias	Cancer Care Ontario
Michelle	Aspden	OTN
Natalie	Aubin	North East - Northeast Cancer Centre
Debbie	Barnard	Health Science North
Michael	Barrett	South West LHIN
Carole	Beals	Royal Victoria Regional Health Centre
Nicole	Beben	Canadian Partnership Against Cancer
Chaim	Bell	Cancer Quality Council of Ontario; Mt. Sinai
Douglas	Bell	CMPA
Susan	Blacker	Toronto Central - Princess Margaret Hospital
Irene	Blais	Cancer Care Ontario
Brigitta	Bokkers	Cancer Care Ontario
Jeff	Booth	Windsor Regional Cancer Program
Laurie	Bourne	Cancer Care Ontario
Michael	Brundage	Cancer Quality Council of Ontario; Queen's University
Phil	Burak	Cancer Care Ontario
Laura	Burnett	Canadian Cancer Society
Scott	Campbell	Cancer Care Ontario
Stephanie	Carpenter	Accreditation Canada
Dafna	Carr	Cancer Care Ontario
Brenda	Carter	Cancer Centre of Southeastern Ontario
Roger	Cheng	Institute for Safe Medical Practices Canada
Andrew	Choate	Patient and Family Advisory Council, Cancer Care Ontario
Lillian	Clarke	Patient and Family Advisory Council, Cancer Care Ontario
Jenny	Cockram	Cancer Quality Council of Ontario; J. Cockram Associates Ltd.
Rebecca	Comrie	Cancer Quality Council of Ontario Secretariat
Ruthe Anne	Conyngham	Cancer Quality Council of Ontario; London Health Sciences Centre
Lindsey	Crawford	North Simcoe Muskoka Regional Cancer Centre
Agnes	Czevar	Grand River Regional Cancer Centre

First name	Last name	Organization
Jennifer	D'Amore	Cancer Care Ontario
Claudia	Den Boer Grima	Windsor Regional Cancer Program
David	Deveau	Jazz Airlines
Andrea	Docherty	Thunder Bay Regional Health Sciences Centre Regional Cancer Care
Lee	Donohue	Champlain Regional Cancer Program
Winnie	Doyle	Cancer Quality Council of Ontario; St. Joseph's Healthcare
Junell	D'Souza	Cancer Care Ontario
Monika	Duddy	Cancer Care Ontario
Tamara	Dus	RS McLaughlin Durham Regional
Craig	Earle	ICES
Katherine	Enright	Trillium Health Partners
Sarah	Etheridge	Southlake Regional Health Centre
Bill	Evans	Oncosynthesis Consulting Inc.
Lisa	Favell	Cancer Care Ontario
Susan	Fitzpatrick	Ministry of Health and Long-Term Care
Brenda	Fleming	South West
Nicoda	Foster	Cancer Quality Council of Ontario Secretariat
Jennifer	Foster	Toronto
Colleen	Fox	Cancer Care Ontario
Ann	Fudge-Rawson	Cancer Care Ontario
Jason	Garay	Cancer Care Ontario
Scott	Gavura	Cancer Care Ontario
Sophie	Georgas	Ministry of Health and Long-Term Care
Janice	Giesbrecht	Niagara Health
Rachel	Gilbert	UHN- Human Era
Jodeme	Goldhar	Toronto CCAC
Angelika	Gollnow	Cancer Care Ontario
Mary	Gospodarowicz	Princess Margaret Hospital
Maria	Grant	Cancer Care Ontario
Esther	Green	Cancer Care Ontario
Melissa	Griffin	UHN- Human Era
Lynn	Guerriero	Cancer Care Ontario
Victoria	Hagens	Cancer Care Ontario
Farzana	Haji	Cancer Quality Council of Ontario Secretariat
Ruth	Hall	Ontario Stroke Network
Margaret	Hart	Lakeridge Health
Tamara	Harth	Cancer Care Ontario
Mark	Hartman	Northeast Cancer Centre/Health Sciences North

First name	Last name	Organization
Rebecca	Harvey	Cancer Care Ontario
Caroline	Heick	CIHI
Sherrie	Hertz	Cancer Care Ontario
Wade	Hillier	CPSO
Amber	Hunter	Cancer Care Ontario
Keely	Hyatt	Cancer Care Ontario
Jonathan	Irish	Cancer Care Ontario
Tony	Jocko	Union of Ontario Indians
Neil	Johnson	London Regional Cancer Program
Barbara	Jones	Central LHIN
Martin	Kabat	Canadian Cancer Society
Leonard	Kaizer	Cancer Care Ontario
Maggie	Keresteci	OMA
Alethea	Kewayosh	Cancer Care Ontario
Nevina	Kishun	Shoppers Drug Mart
Jack	Kitts	Cancer Quality Council of Ontario; The Ottawa Hospital
Paula	Knight	Cancer Care Ontario
Greg	Knight	Grand River Regional Cancer Centre
Nancy	Kraetschmer	Cancer Care Ontario
Michelle	Krivel	Cancer Care Ontario
Monika	Krzyzanowska	University Health Network
Ed	Kucharski	Sherbourne Health Centre
Vishal	Kukreti	Cancer Care Ontario
Darren	Larsen	Cancer Quality Council of Ontario; Ontario MD
Andreas	Laupacis	Cancer Care Ontario
Calvin	Law	Odette Cancer Centre
Vicki	Lejambe	St. Elizabeth Health Care
Judy	Linton	Grand River Regional Cancer Centre
Anna	Liovas	Cancer Care Ontario
Elizabeth	Lockhart	Cancer Care Ontario
Heather	Logan	CAPCA
Brenda	Lynn	Ontario Renal Network
Laura	Macdougall	Cancer Care Ontario
Marnie	MacKinnon	Cancer Care Ontario
Hugh	MacLeod	Canadian Patient Safety Institute
Joanne	MacPhail	Patient and Family Advisory Council, Cancer Care Ontario
Catherine	Mahut	Southlake Regional Hospital
Allan	Malek	OPA

First name	Last name	Organization
Oonagh	Maley	Cancer Care Ontario
Ruhee	Mardhani	Cancer Quality Council of Ontario Secretariat
Garth	Matheson	Cancer Care Ontario
John	Mathews	Windsor Regional Hospital
Alison	McAndrew	Toronto Central Regional Cancer Program
Craig	McFadyen	Cancer Quality Council of Ontario; Carlo Fidani Peel Regional Cancer Centre
Tom	McHugh	RS McLaughlin Durham Regional Cancer Centre
Virginia	McLaughlin	Cancer Quality Council of Ontario
Robin	McLeod	Cancer Care Ontario
Scott	McLeod	Central West LHIN
Gaylene	Medlam	Credit Valley Hospital
Elaine	Meertens	Cancer Care Ontario
Saul	Melamed	Cancer Care Ontario
Ralph	Meyer	Juravinski Hospital and Cancer Center
Caitlin	Mills	Cancer Care Ontario
Jennifer	Montgomery	Royal Victoria Regional Health Centre
Lesley	Moody	Cancer Care Ontario
Jane	Murkin	NHS Scotland
Rohini	Naipaul	Cancer Care Ontario
Karen	Nguyen	Cancer Care Ontario
Jason	Pantarotto	The Ottawa Hospital
Charvi	Patel	Cancer Care Ontario
Jillian	Paul	Ministry of Health and Long-Term Care
Alice	Peter	Cancer Care Ontario
Rowena	Pinto	Canadian Cancer Society
Aaron	Pollett	Cancer Care Ontario
Dawn	Powell	Cancer Quality Council of Ontario; Dawn M Powell Appraisals Inc.; Patient and Family Oncology Partnership Council, Thunder Bay
Linda	Rabeneck	Cancer Care Ontario
Erin	Rae	Cancer Care Ontario
Rami	Rahal	Canadian Partnership Against Cancer
Carol	Rand	Hamilton Niagara Haldimand Brant
Lindsay	Reddeman	Cancer Care Ontario
Robin	Reece	CPSO
Michelle	Rey	Cancer Quality Council of Ontario Secretariat
Jillian	Ross	Cancer Care Ontario
Katrina	Santiago	Cancer Quality Council of Ontario Secretariat

First name	Last name	Organization
Pamela	Savage	UHN
Karen	Sequeira	OHA
Michael	Sharpe	Princess Margaret Hospital
Donna	Sheehan	Cancer Care Ontario
Michael	Sherar	Cancer Care Ontario
Simron	Singh	Sunnybrook Health Sciences Centre
Andy	Smith	Cancer Quality Council of Ontario; Sunnybrook Health Sciences Centre
Iva	Stankovic	Ontario Hospital Association
Janice	Stewart	Odette Cancer Centre
Robbie	Stewart	Cancer Care Ontario
Patricia	Sullivan-Taylor	Ministry of Health and Long-Term Care
Ken	Sutcliffe	Cancer Care Ontario
Reena	Tabing	Cancer Care Ontario
Joshua	Tepper	HQO
Craig	Thompson	Womens College Hospital
Harvey	Thomson	Cancer Care Ontario
Donna	VanAllen	Waterloo Wellington
Marcia	Visser	OHA
Kathy	Vu	Cancer Care Ontario
Tara	Walton	Cancer Care Ontario
Maggie	Wang Maric	Cancer Care Ontario
Padraig	Warde	Cancer Care Ontario
Sallie	Weaver	John’s Hopkins University
Woodrow	Wells	Southlake Regional Health Centre
Jackson	Wood	Cancer Care Ontario
Dora	Yuen	Cancer Care Ontario
Jennifer	Zelmer	Canada Health Infoway
Elizabeth	Zucchiatti	Cancer Care Ontario