ISCOME
International Society for
Communication Science and Medicine

15-16 June **2015**

The Golden Bridge: Communication and Patient Safety

Montecatini Terme (Italy)

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The ISCOME 2015 conference is organized in collaboration with the Center of Patient Safety of the Italian Tuscany Region. ISCOME particularly thanks Tommaso Bellandi, Riccardo Tartaglia, Elena Beleffi, Giulio Toccafondi and Sara Albolino for their outstanding support. In addition, the following organizations are supporting ISCOME 2015 as patrons:

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Meaningful Measuren

WELCOME TO THE ISCOME 2015 CONFERENCE

Dear delegates,

It is my pleasure to welcome you to the ISCOME 2015 conference in Montecatini Terme. For this year's meeting, ISCOME has chosen the theme "The Golden Bridge: Communication and Patient Safety." I would like to take a minute to reflect on this theme in light of the current state of affairs and the broad knowledge that we have accumulated in the field of patient safety over the past few years.

Among numerous renowned speakers at this year's conference, we have the honor to host and welcome a key figure in patient safety who many consider the "founding parent" of the patient safety discipline, Sir Liam Donaldson, who states in his plenary abstract that "despite a commitment to providing safe care becoming a declared priority in almost all healthcare systems of the world over the last decade, true progress in reducing the burden of avoidable harm has been very disappointing." One of the key problems Sir Liam will highlight in his ISCOME 2015 plenary address is "weak communication at all levels." Underlining this notion, the literature has been consistently pointing at communication as one of the main contributing factors to patient safety events. At the same time, effective communication has been recognized as a key mechanism to preventing patient harm.

Despite its substantial function in the provision of safe care, communication interventions have been rare and not as impactful as they should have been. In other words, communication as a "golden path" to better and safer care has not affected impressive improvements. The ISCOME 2015 conference theme is dedicated to this phenomenon and reframes communication as a "golden bridge." Golden as a reflection of the valuable and indispensable function of communication in healthcare delivery, and bridge implying the essential necessity to establish interdisciplinary collaborations between communication science and healthcare that join existing bodies of knowledge and draw new transdisciplinary pathways to impact the quality and safety of healthcare in visible ways.

To dedicate some intensive time to this goal within the scope of its two main conference days, ISCOME 2015 is featuring two innovative roundtable discussion panels that will shed interdisciplinary perspectives onto two critical communication-prone challenges in the patient safety domain. The first panel focuses on cross-professional interactions, which are recognized in the literature as a main contributor to patient harm. In other words, when providers communicate well with each other, patient health is improved, and when communication fails, health outcomes are significantly compromised. From this panel again emerges the notion of the "Golden Bridge", implying that casting a bridge across professions improves the quality and safety of care for all involved. Communication constitutes the means to building this bridge.

The second ISCOME 2015 roundtable discussion panel invites leading scholars from a variety of disciplines to immerse themselves in the current state of knowledge and to explore heuristic directions in the area of safe provider-patient communication. We are honored to host well-known thought-leaders on this panel who will close with some reflections on directions for future transdisciplinary research projects and practice solutions.

As briefly mentioned above, we are particularly pleased to welcome Sir Liam Donaldson to the ISCOME 2015 conference, who will deliver the final plenary address on Tuesday afternoon reflecting on the horizons for patient safety. Sir Liam Donaldson's address will be responded to in a closing roundtable discussion that features well-known influential decision-makers in health care and patient safety. Led by WHO patient safety champion Brian Stafford and journalist Roberto Satolli, the invited panelists will reflect on Sir Liam's plenary address and the conference discussions at large from an applied point of view.

This is the second conference ISCOME (formerly the "COME" group) is organizing on this important and stimulating topic area, and I am very pleased with the interactivity that has emerged among the current ISCOME members during the past two years, which evidences that the mission of ISCOME is at work. Since COME 2013, we have successfully cast a fruitful bridge between numerous communication scientists and scholars in health-related fields, and ISCOME has become a sustainable and visible platform for scientists and practitioners to exchange perspectives, reflect on existing data, collaborate on research and practice interventions, and develop interdisciplinary implementations that promise to trigger measurable impact.

This interdisciplinary interactivity is the driving engine and still today maintains the existence of ISCOME as a young and dynamic society. It is in that sense that I encourage everyone – presenters and non-presenters at this year's conference – to actively join the group and engage yourself in this important and stimulating dialogue. Because if there is one common denominator that brought all of us to Montecatini Terme this year, it is that common purpose to engage in innovative transdisciplinary directions that will make healthcare a better and safer process for everyone.

On behalf of ISCOME, I wish you a productive, satisfying and successful conference experience and look forward to welcoming you to the group!

Collegiate regards,

Prof. Dr. Annegret Hannawa
ISCOME President

WELCOME TO THE ISCOME 2015 CONFERENCE

Dear Guests,

My warmest welcome to Montecatini Terme! I am very pleased and honored to host the ISCOME 2015 conference at our beautiful venue Salone Regina.

Montecatini Terme is well-known for its hospitality and the quality of life it offers to its inhabitants and visitors. The properties of the thermal water springing from its soil have been known since the times of the ancient Romans. Even back in those times, pilgrims and soldiers visited here to take a warm bath. More recently, in the 19th century, the curative effects of the water to treat digestive diseases emerged while the mud started to be used to treat muscle-skeletal disorders. At that time, our magnificent thermal establishment was built, restored, and then enlarged during the early 20th century. Today, our mud is also being used for make-up products by national and international companies. For example, Madonna's natural beauty products for skin care are made with our mud!

Montecatini Terme became famous as a touristic place in the 19th century, when Leopold, the Duke of Tuscany, often visited with his court of nobles and servants. His former holiday house, located in Viale Verdi, now hosts the administration of Terme's company and public exhibitions. The most famous amateur of Montecatini during the 19th century was certainly the famous romantic composer Giuseppe Verdi, who in fact is remembered by the naming of the city's main avenue

The tourism increased after the second World War, especially during the "maginificent sixties". At that time, Montecatini Terme was one of the most popular places for the "dolce vita", also for the nightlife with many well-known actors, musicians and sports champions who spent their vacations here. You can see the names of the stars on the plates positioned on the sidewalk of Viale Verdi, just like in Hollywood!

During the past two centuries, the lower end of town has significantly grown in size, while Montecatini Alto (the higher end of town) maintained its original middle-age flavor. In the meantime, the town has become a popular destination for scientific conferences, especially in the medical arena, thanks to the quality of the hotels, restaurants and facilities, as well as for the quiet and relaxing atmosphere that facilitates reflection, creativity and social relations. In the past five years, Montecatini Terme has hosted important events, such as the World Championship of Cycling, the Miss Italia Beauty Contest, and international exhibitions of visual arts at the new museum located on the first floor of our City Hall.

To conclude, Montecatini Terme lies in the heart of beautiful Tuscany and offers to be a starting point for your visit of our beautiful region – both its cultural heritage in the cities, and the more natural destinations that can be reached in short one-day trips.

In this spirit, I wish you a successful conference and hope you will enjoy your stay in our town and region!

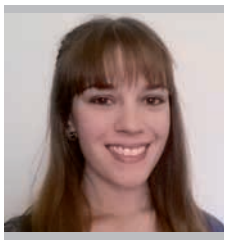
Warm regards,

Giuseppe Bellandi
Mayor of Montecatini Terme

THE ISCOME 2015 CONFERENCE TEAM

Annegret F. Hannawa, Ph.D., is Assistant Professor of Health Communication at the Faculty of Communication Sciences at the University of Lugano (Università della Svizzera italiana). Prior to joining USI, she served as Assistant Professor of Health Communication and Empirical Research Methods at Wake Forest University, North Carolina. Professor Hannawa's scientific expertise lies in the domains of interpersonal communication and advanced quantitative methodology. Her research agenda focuses on transdisciplinary approaches to optimizing health care delivery, and positive health outcomes that can be achieved through competent interpersonal interaction. Her most recent grant (funded by the Swiss National Science Foundation) conceptualizes and operationalizes Medical Error Disclosure Competence (MEDC) as an empirical construct. Furthermore, she has developed a Tool for Retrospective Analysis of Critical Events (TRACE) in collaboration with Debra Roter, which operationalizes a theoretically framed, interdisciplinary conceptualization of medical error. Her research also examines physicians' verbal and nonverbal disclosure styles of medical errors to patients that facilitate positive and negative physiological, psychological, relational, organizational, and systemic health outcomes. Prof. Hannawa founded and now presides the International Society for Communication Science and Medicine (ISCOME), which actively pursues innovative interdisciplinary research collaborations to improve patient safety.

Marta Dell'Adami De Tarczal is a student at Università della Svizzera italiana where she attends a Master in Marketing. She studied Philosophy at Università Cattolica del Sacro Cuore in Milan for her bachelor. Very passionate about psychology she developed a strong interest in consumer behavior, which is the field of study of her Master thesis.



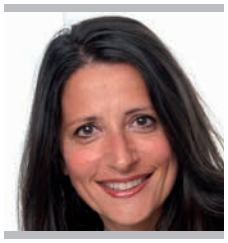
Maja Jovičić is a student of Università della Svizzera Italiana where she attends the Master in Corporate Communication. Currently still in her first year, she is starting to research her thesis on the subject of mediation.
She has two bachelor degrees (in international and national law), obtained at the University of Business Studies in Banja Luka, Bosnia and Herzegovina.

Riccardo Tartaglia is a medical doctor, specialist in occupational medicine, hygiene and public health, and certified European ergonomist. He was Scientific Director of the Ergonomics Research Centre of Healthcare Trust Florence. Since 2004 he is director of the Centre for Clinical Risk Management and Patient Safety, located at the Department of Health of the Tuscany Region in Florence and Coordinator of the Italian Committee for Patient Safety. He is adjunct professor of Ergonomics at University of Florence and Scientific Coordinator of the Advanced Course in Clinical Risk Management at Sant'Anna Superior School - University of Pisa. He is Vice-President and founder of the Italian Society for Safety and Quality of Transplants, and Past President of the Italian Ergonomics Society. Riccardo Tartaglia is author of numerous scientific articles (for a list, visit Medline or Researchgate) and of books published by Springer, Taylor & Francis, and Il Mulino.

Tommaso Bellandi is a certified ergonomist/human factors engineer (Eur.Erg.). He graduated at the University of Siena in 2001 in Communication Science and received a Master in Ergonomics and Human Factors in 2003 and a PhD in ICT in 2006 at the University of Florence. During his Ph.D., he attended a visiting program at the Clinical Safety Research Unit of the Imperial College in London and at the Danish Society for Patient Safety in Copenhagen. Since 2004, he works at the Centre for Clinical Risk Management and Patient Safety, located at the Department of Health of the Tuscany Region in Florence, where he has the responsibility for quality and safety in the Regional Transplant Organization. He also coordinates the regional reporting and learning system of adverse events and the northwest network for patient safety. He teaches ergonomics and patient safety at the University of Florence and at the Sant'Anna School of Advanced Studies in Pisa. He is author of more than 60 publications in Italian and international journals and of numerous books on patient safety, human factors and ergonomics in healthcare. Bellandi is member of the board of the Italian Ergonomics Society, with the role of President of the national assessment board of professional ergonomists and member of the Council of the Centre for the Registration of the European Ergonomists.

THE ISCOME 2015 CONFERENCE TEAM

Elena Beleffi works since 2005 at the Centre for Clinical Risk Management and Patient Safety, at the Department of Health of the Tuscany Region in Florence, where he has the role of office manager taking care of the organizational aspects of the activities of the Centre.
She manages the Secretariat of the national network of Italian Regions for Patient Safety.
She recently graduated at the Uninettuno International University in Communication Science and she is actively involved in initiatives of the Centre focused on involvement and empowerment of citizens and patients in health policies. She contributes to the organization and to the definition of a periodical training program designed for representatives of patient and citizen associations on patient safety and to a series of other activities dedicated to the participation of trained patients to policies on patient safety.



Silvia Polvani
ISCOME expresses a special thanks to Silvia Polvani at Eleven Conference for her professional and enthusiastic support in organizing and implementing the ISCOME 2015 conference in Montecatini Terme.

ISCOME 2015 SCIENTIFIC COMMITTEE

ISCOME thanks the following colleagues for serving as abstract reviewers for the ISCOME 2015 conference.

Sara Albolino
Center of Patient Safety, Italy

Sebastiano Bagnara
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Tommaso Bellandi
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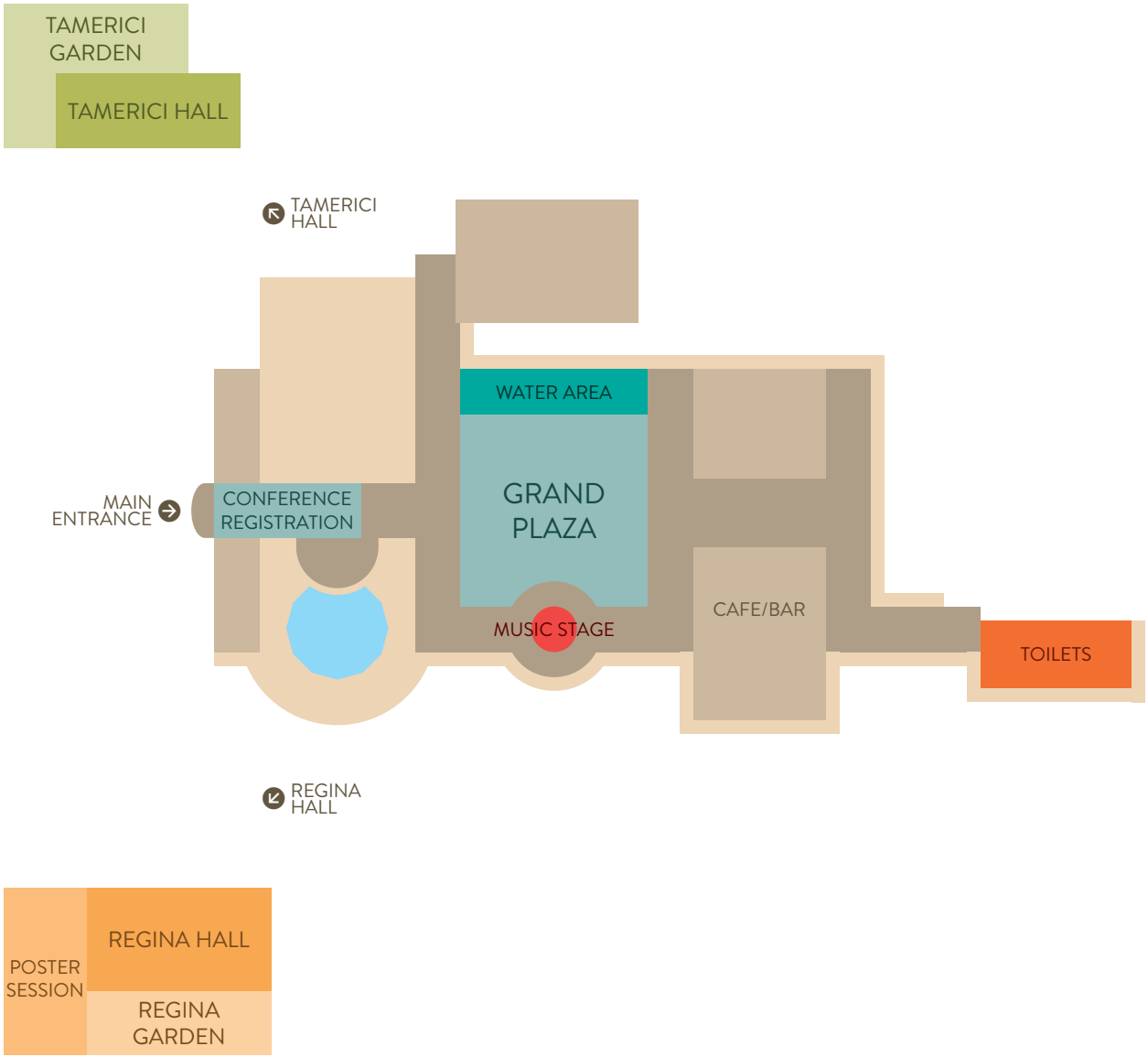
ISCOME 2015 CONFERENCE FLOORPLAN

CONFERENCE VENUE:
TERME TETTUCCIO, TERME TAMERICI, MONTECATINI TERME



ISCOME 2015 PROGRAM OVERVIEW

SUNDAY, JUNE 14th

Time	Event	Location
2:00 pm	**Conference Registration** (open until 5 pm)	Entrance Area
4:00 pm	**Guided Wine Tour** (social event for speakers - additional fee)	Meeting Point: Entrance Area

MONDAY, JUNE 15th

Time	Event	Location
7:45 am	**Conference Registration** (open until 5:00 pm)	Entrance Area
8:00 am	**Informal Gathering** with Water Tasting	Grand Plaza
8:45 am	**Opening Address**, Annegret F. Hannawa (ISCOME President), Dr. Giuseppe Bellandi (Mayor, Montecatini Terme), and Dr. Tommaso Bellandi (Center for Patient Safety, Tuscany)	Regina Hall
9:30 am	**Plenary:** "The Error(s) of our Ways: Communicating Competently for Health and Safety," Brian Spitzberg Chair: Annegret Hannawa	Regina Hall
10:30 am	**Coffee Break**	Grand Plaza
11:00 am	**Workshop** "Handover skills" Giulio Toccafondi and Sara Albolino	Grand Plaza
11:00 am	**Oral Presentations** "Front-line experiences in quality and safe care" Respondent: Debra Roter Chair: Laura Rasero	Regina Hall
	Speedy Presentations "Litigation; Technology; Diagnostic error" Chair: Elena Beleffi	Tamerici Hall
12:00pm	**Oral Presentations** "Innovations for healthcare quality and safety" Respondent: Antonio Rizzo Chair: Pascale Carayon (Wisconsin-Madison, HF training – Monday)	Regina Hall
	Speedy Presentations "Reporting; Patient involvement" Chair: Elena Vegni	Tamerici Hall
1:00 pm	**Lunch**	Grand Plaza
2:00 pm	**Roundtable Discussion:** "Cross-Professional Communication and Patient Safety" Chairs: Debra Roter and Richard Street Panelists: R. Juhasz, J. Øvretveit, A. Rizzo , B. Spitzberg, A. Wu	Regina Hall
3:30 pm	**Coffee Break**	Regina Garden
4:00 pm	**Plenary:** "Human Factors in Patient Safety" Riccardo Tartaglia Chair: Sara Albolino	Regina Hall
5:00 pm	**Poster Session** with Aperitivo	Regina Open Gallery
5:00 pm	**Workshop** "Supporting the Second Victims of Adverse Events" Albert Wu	Tamerici Hall

ISCOME 2015 PROGRAM OVERVIEW

5:00 pm	**Workshop** "Using evidence and research to assess and improve patient and provider communications" John Øvretveit	Regina Hall
8:00 pm	**ISCOME 2015 Conference Banquet**	Grand Hotel La Pace

TUESDAY, JUNE 16th

Time	Event	Location
8:00 am	**Conference Registration** (open until Noon)	Entrance Area
8:30 am	**Speedy Presentations** "Handover; Communication skills; Education" Chair: Giulio Toccafondi	Regina Hall
	Informal scholar-to-scholar meetings with Live Classical Music	Grand Plaza
9:30 am	**Plenary:** "Clinician-Patient Communication and Health Outcomes" Richard Street Jr. Chair: Wayne Beach	Regina Hall
10:30 am	**Coffee Break**	Grand Plaza
11:00 am	**Top Paper Panel** Chairs: Annegret Hannawa and Tommaso Bellandi	Regina Hall
12:00pm	**Top Student Paper Panel** Chairs: Annegret Hannawa and Tommaso Bellandi	Regina Hall
1:00 pm	**Lunch**	Grand Plaza
2:00 pm	**Roundtable Discussion:** "Provider-Patient Communication and Patient Safety" Chairs: John Øvretveit and Brian Spitzberg Panelists: W. Afifi, W. Beach, J. Pham, D. Roter, R. Street, E. Vegni	Regina Hall
3:30 pm	**Coffee Break**	Regina Garden
4:00 pm	**Plenary:** "Horizons for Patient Safety," Sir Liam Donaldson Chair: Annegret Hannawa	Regina Hall
5:00 pm	**Roundtable Discussion:** "Reflections on the Past, Present and Future of Patient Safety" Chairs: Tommaso Bellandi, Brian Stafford Panelists: J. Bacou, S. Bovenga, N. Dhingra, G. Gensini, B. Kutryba, F. Vimercati	Regina Hall
6:00 pm	**Closing remarks on ISCOME 2015**, Annegret F. Hannawa	Regina Hall
6:30 pm	**End of ISCOME 2015 Conference**	

ISCOME 2015 PLENARY SPEAKERS

MONDAY, JUNE 15th

The Error(s) of our Ways: Communicating Competently for Health and Safety

Brian Spitzberg, Ph.D.

Abstract

Communication is integral to personal, relational, and institutional health, and to the fulfillment of health care objectives. The role of communication is paradoxical—it is simultaneously fragile and error-prone, and yet highly resilient and adaptable to error. This presentation examines the nature of communication competence as an organizing perspective to interaction in the health care setting. It presents a set of axioms and a model to organize understandings of communication, and examines some of the principles by which more competent communication might manage the fundamental tensions between the task and relational concerns of the client-provider interaction. The presentation will also seek to articulate some of the core issues facing the interdisciplinary pursuit of enhancing safety and reducing errors in health care delivery through better communication.

Biography

Brian H. Spitzberg received his Ph.D. in Communication Arts & Sciences at the University of Southern California in 1981. He is currently Senate Distinguished Professor in the School of Communication at San Diego State University. He is the 2011 honoree of the National Communication Association Larry Kibler Memorial Award, and in 2009 he received the Western States Communication Association Scholar Award for lifetime contribution to the discipline and association. His 1994 coauthored book The Dark Side of Relationship Pursuit: From Attraction to Obsession and Stalking, won the biennial International Association for Relationship Research Book Award in 1996. He is author or coauthor of over 100 scholarly articles and book chapters, and has coauthored or co-edited several scholarly books on communication competence, communication skills assessment, and the dark side of communication. His primary areas of research involve interpersonal communication skills, meme diffusion, conflict, aggression, and stalking.

MONDAY, JUNE 15th

Human Factors in Patient Safety

Riccardo Tartaglia, Ph.D., M.D.

Abstract

In the work of doctors and nurses, manual activities are at the basis of the delivery of care, especially in surgery and nursing. These manual activities shape the way doctors and nurses think, elaborate a diagnosis, and enact a treatment. However, doctor-patient interactions and particularly non-verbal communication are important for team coordination. According to the emerging evidence on embodied cognition, reasoning, perception, memory and attention develop from interactions between human beings and their environments. Therefore, knowledge emerges from social interactions, and good performance is the result of effective communication and coordination between professionals, teams and units. Human factors research needs to take into account this challenge and re-think the organization of healthcare services, the training of clinicians, and the way services are co-designed and co-delivered with patients and informal caregivers. Patient safety can be a powerful driver to envision the embodied nature of cognition when safety is incorporated in the default practice within a community, as well as when an adverse event provokes a breakdown in the flow of actions requiring a deliberate process of reflection to make sense of what went wrong.

Biography

Riccardo Tartaglia is a medical doctor, specialist in occupational medicine, hygiene and public health, and certified European ergonomist. He was Scientific Director of the Ergonomics Research Centre of Healthcare Trust Florence. Since 2004 he is director of the Centre for Clinical Risk Management and Patient Safety, located at the Department of Health of the Tuscany Region in Florence and Coordinator of the Italian Committee for Patient Safety. He is adjunct professor of Ergonomics at University of Florence and Scientific Coordinator of the Advanced Course in Clinical Risk Management at Sant'Anna Superior School - University of Pisa. He is Vice-President and founder of the Italian Society for Safety and Quality of Transplants, and Past President of the Italian Ergonomics Society. Riccardo Tartaglia is author of numerous scientific articles (for a list, visit Medline or Researchgate) and of books published by Springer, Taylor & Francis, and Il Mulino.

ISCOME 2015 PLENARY SPEAKERS

TUESDAY, JUNE 16th

Clinician-Patient Communication and Health Outcomes

Richard L. Street, Jr.

Abstract

From a quality of care perspective, patient safety falls under the general rubric of optimizing patients' experiences and outcomes when receiving health care. Effective clinician-patient communication is a critical component of quality health care, but the manner in which it contributes to better health outcomes can be complicated and is poorly understood. This presentation will focus on two issues. First, pathways linking features of clinician-patient communication to health outcomes are discussed along with an example of how one might approach this issue. Second, a perspective on how clinicians and researchers can more effectively assess the quality of patients' experiences with care is offered along with recent data from a study that assessed outcomes of communication in cancer care from a communication function perspective.

Biography

Richard L. Street, Jr. PhD, is Professor of Communication at Texas A&M University and Professor of Medicine at Baylor College of Medicine. His research focuses on clinician-patient communication, pathways linking communication to improved health outcomes, and strategies for increasing patient involvement in care. He has published over 150 articles and book chapters, as well as a number of books, monographs, and special issues of various journals. In 2003, he was named Outstanding Health Communication Scholar by the International Communication Association. In 2008, he received the L. Donohew Health Communication Scholar Award from the University of Kentucky. In 2010, he was awarded Texas A&M Association of Former Students Distinguished Achievement in Research Award. In 2012, he was given the George L. Engel award by the American Academy on Communication in Healthcare for career contributions to the research practice, and teaching of effective healthcare communication skills.

TUESDAY, JUNE 16th

Horizons for Patient Safety

Sir Liam Donaldson

Abstract

Despite a commitment to providing safe care becoming a declared priority in almost all healthcare systems of the world over the last decade, true progress in reducing the burden of avoidable harm has been very disappointing. The weaknesses in many programmes include: low engagement of front-line clinical staff, lack of protected time to study adverse events, unimaginative use of data, and weak communication at all levels. A fresh look is needed and the importance of growing a new generation of patient safety leaders remains a top priority.

Biography

Professor Sir Liam Donaldson is recognised as an international champion of patient safety and public health. He was the foundation chair of the World Health Organisation World Alliance for Patient Safety, launched in 2004. He is a past vice-chairman of the World Health Organisation Executive Board. He is now the World Health Organisation's Envoy for Patient Safety and Chairman of the Independent Monitoring for the Polio Eradication Programme. In the UK, he is currently Chair of Health Policy at Imperial College London and Chancellor of Newcastle University. Prior to this appointment, Sir Liam was the Chief Medical Officer for England, and the United Kingdom's Chief Medical Adviser, from 1998-2010. During this time, he held critical responsibilities across the whole field of public health and health care. As the United Kingdom's chief adviser on health issues, he advised the Secretary of State for Health, the Prime Minister and other government ministers. He has produced landmark reports which have set health policy and legislation in fields such as stem cell research, quality and safety of health care, infectious disease control, patient empowerment, poor clinical performance, smoke free public places, medical regulation, and organ and tissue retention.

Sir Liam initially trained as a surgeon in Birmingham and went on to hold teaching and research posts at the University of Leicester. In 1986, he was appointed Regional Medical Officer and Regional Director of Public Health for the Northern Regional Health Authority. He Liam has received many public honours: 12 honorary doctorates from British universities, eight fellowships from medical royal colleges and faculties, and the Gold Medal of the Royal College of Surgeons of Edinburgh. He was the Queen's Honorary Physician between 1996 and 1999. He was knighted in the 2002 New Year's Honours List.

ISCOME 2015 ROUNDTABLE PANELISTS

Walid A. Afifi

Walid A. Afifi (PhD, University of Arizona) is Professor and Chair of the Department of Communication Studies at the University of Iowa, where he also has a joint appointment with the College of Nursing. He has also had an appointment as Visiting Professor in the Faculty of Health Sciences at the American University of Beirut. He is an author on over 60 articles, chapters, and books, and has served as chair of the Interpersonal Division for both the National Communication Association and the International Communication Association. His program of research revolves around uncertainty and information-management decisions (typically in health contexts) and has led to the development and refinement of the Theory of Motivated Information Management.

Jean Bacou

Jean Bacou, MD, Advisor International Affairs & Patient Safety – French National Authority for Health is coordinator of the European Network for Patient Safety and Quality of care (PaSQ) involving official representatives of the 28 EU Member States, EU stakeholders and international organisations. He is a Medical Doctor specialized in Public Health.

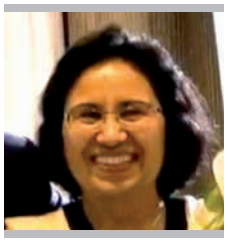
Wayne A. Beach

Dr. Beach is Professor in the School of Communication at SDSU, Adjunct Professor, Department of Surgery, and Member of the Moores UCSD Cancer Center, University of California, San Diego. His research and teaching focus on the convergence of conversational and institutional interactions. He has pioneered diverse studies focusing on the social organization of verbal and embodied features of everyday talk and action. A particular concern with health and illness has given rise to long-term investigations of how family members talk through cancer on the telephone, medical interviewing in primary, preventive, and oncological care, and related illness dilemmas (e.g., bulimia, obesity, chest pain, cancer diagnosis, treatment, and prognosis).
He is the author of more than 85 articles and chapters, as well as Conversations about Illness (1996) and A Natural History of Family Cancer (2009), which received two prestigious book awards from the National Communication Association: The 2010-2011 Outstanding Book Award (Health Communication Division) and the Outstanding Scholarship Award (Language & Social Interaction Division). He also edited the first Handbook of Patient-Provider Interactions (2013) – a compilation of over 50 seminal studies advancing understandings of communication during medical interviews and related clinical encounters. Other recent awards include the Translational Entertainment and Education Award from George Mason University, SDSU's President's Leadership Fund and Dean's Excellence Awards, and SDSU's Faculty 'Monty' and Professor of the Year Awards for Outstanding Research & Teaching Contributions.
External funding for Dr. Beach's research has been awarded from the National Institutes of Health (NIH)/National Cancer Institute (NCI), the American Cancer Society (ACS), and several philanthropic foundations in San Diego. His current funded work examines how patients make available and oncologists respond to hopes, fears, and uncertainties about cancer. He is also collaborating with theatre professionals in a production – When Cancer Calls. . . – funded by NCI and adapted from actual family phone calls examined in A Natural History of Family Cancer, documenting how family members communicate about and manage cancer on the telephone. A national documentary film is also being produced, in collaboration with the UCSD Moores Cancer Center, on communication, compassion, and cancer care (in clinics and homes) throughout cancer journeys.

Sergio Bovenga

Sergio Bovenga is a surgeon, he practiced the general surgery for twenty years, then he specializez in quality of healthcare, patient safety and clinical risk management, and more recently in the assessment of health services .
He is currently CInical Risk Manager and Director of the Department of Planning, Programming, Control of Grosseto local health services and President of the Medical Association of Grosseto.
At Italian national level, he is Director of the Central Committee of FNOMCEO (the national medical federation), where he is in charge as the Head of Delegation for Italy in the European Association of Hospital Doctors. He is part of the National Council ENPAM and president of the Consortium for the Management of Registries of Health Professions (Co.Ge.APS).

ISCOME 2015 ROUNDTABLE PANELISTS



Neelam Dhingra

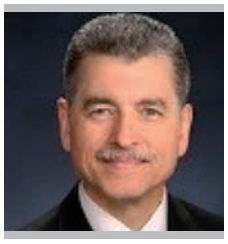
Dr Neelam Dhingra is Coordinator for the Patient Safety and Quality Improvement Unit, in the Service Delivery and Safety Department at the World Health Organization headquarters in Geneva, Switzerland. In this role, Dr Dhingra leads WHO's efforts at providing strategic leadership on patient safety and quality improvement within the context of improving people-centred integrated health services delivery and strengthening system for safety and quality of health services globally, and coordinates WHO's work for improvement of safety and quality of health care, including global safety partnerships, injection safety, safety and quality tools and checklists, patient and family engagement and patients for patient safety, infection prevention and control and patient safety and quality education and training. Since joining WHO in 2000, Dr Dhingra had been providing strategic leadership and facilitating multi-country support for strengthening the delivery and safety of transfusion and laboratory services, as part of the broader health care system. Prior to joining WHO, Dr Dhingra served as a medical faculty in a large, tertiary care University Teaching hospital in New Delhi, India for 14 years, also heading the clinical pathology, blood transfusion and laboratory services. She obtained her medical graduation and post-graduation qualifications from New Delhi and fellowships in the UK as a haematologist, laboratory and transfusion medicine expert. Dr Dhingra's areas of expertise are policy and strategy formulation; safety and quality of health services; vigilance, reporting and learning systems; quality and risk management systems; patient and community engagement; and assessments, monitoring, evaluation and operational research, among others.

Gian Franco Gensini

Gian Franco Gensini is Professor of Internal Medicine at the University of Florence and has been Head of the Faculty of Medicine and Surgery of the University of Florence. He is member of the National Health Research Committee and of the Italian National healthcare guidelines Committee.

He is Editor-in -Chief of the Journal Internal and Emergency Medicine and author of more than 400 scientific publications in national and international biomedical journals.

He has managed to combine professional life and academic interest with the modern needs of different skills in management and also the challenges that technological and scientific progress continues to pose to modern medicine.



Robert S. Juhasz

Robert S. Juhasz, DO, is the 118th president of the American Osteopathic Association (AOA) which represents more than 110,000 osteopathic physicians in the United States. One of his primary initiatives is for AOA, a leader in the field of healthcare, to increase its already-considerable support of medical research.

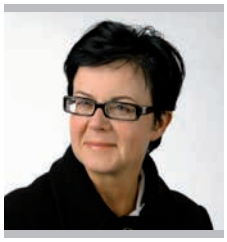
An AOA board-certified internist, Dr. Juhasz serves as president of Cleveland Clinic's South Pointe Hospital where he is dedicated to providing excellence in patient care. He is expert at managing many diverse teams of physicians and other healthcare professionals to promote health as well as patient safety.

A pioneer in the adoption of electronic health records, Dr. Juhasz was actively involved with the implementation of the electronic medical record system at the Cleveland Clinic before many physicians used these systems. In 2005, he participated in a panel with President George W. Bush to discuss the benefits of electronic medical records. He is now interested in the Big Data that is produced from widespread use of such electronic medical records systems to improve preventive care and population health management.

Dr. Juhasz served as an associate dean at the Ohio University Heritage College of Osteopathic Medicine, where he is an associate clinical professor of medicine. He is also assistant clinical professor at the Cleveland Clinic's Lerner College of Medicine at Case Western University in Cleveland.

Dr. Juhasz is a fellow and diplomate of the American College of Osteopathic Internists, and a fellow of the American College of Physicians.

ISCOME 2015 ROUNDTABLE PANELISTS



Basia Kutryba

Basia Kutryba is the co-founder of the first quality institute in CEE and a Senior Adviser at National Centre for Quality Assessment in Health Care (NCQA) in Krakow, Poland. She has played the major role in the development of Polish national, JCAHO based accreditation system and in quality improvement initiatives in other ECC countries as well as in the Middle East.
President of the EU Expert Group on Patient Safety and Quality of care; head of the WHO Collaborating Centre for Developing Quality and Safety in Health Systems in Krakow.
She is the founding member of the Polish Society for Quality Promotion in Health Care (TPJ -1993) and its Vice-president; also a Fellow of the European Society for Quality in Healthcare.

John Øvretveit

Dr. John Øvretveit is Director of Research and Professor of health care innovation implementation and evaluation at the Medical Management Centre, The Karolinska Institute, Stockholm (http://ki.se/en/people/johovr). Dr. Øvretveit's work is based on the belief that organisation and management can bring out both the best and the worst in us, and that the right organisation design is critical for effective healthcare. A theme underlying his work is how practical research can contribute both to better care for patients. Much of his work uses different social sciences to explain and predict events and processes in health care and clinical practice. He was awarded the 2014 Avedis Donabedian international quality award for his work on quality economics and has carried out research and practical projects internationally on quality and safety improvement and implementation since 1985. Translations of some of his 300 peer-reviewed scientific papers and books have been made into nine languages. Six books have won publications awards, including twice winner of the European Health Management Association Award and the Baxter health publication of the year prize, for "Action Evaluations" (2002) and "Health Service Quality" (1992). He is currently a reviewer for and editorial board member of eight scientific health journals, and a board member of the Joint Commission Resources/International, advisor since 1995 to The Netherlands Health Service Research Council.

Julius Pham

Julius Pham is a practicing emergency physician, practicing critical care physician, educator, and patient safety research at the Johns Hopkins University, School of Medicine. His cross-training in two clinical disciplines provides a unique perspective on the presentation and progression of patient illness. As a researcher, Dr. Pham has a PhD in clinical investigation. His area of research involves evaluating the quality and safety of healthcare. Recent publications involve studying adverse event analysis, medical error reporting systems, adverse event reporting system analysis, and medical device safety.

Antonio Rizzo

Full Professor of Cognitive Science at the University of Siena (2003-Present) and Co-Founder of UDOO (2013). Director of the Academy of Digital Arts and Science – ArsNova Siena (2004 – 2010). Chair of the European Association of Cognitive Ergonomics (2000 – 2006). Head oh the Human Factor Group of the Italian National Railways (1996 – 1999). Member of the Scientific Committee of the Programme Incitatif de Recherche sur l'Education et la Formation (PIREF) of the French Government (2002-2003). University Liason for Apple Inc, for the Apple Design Project (1996-1997). Consultant for Philips Design, Simens, Eurocontrol, Trenitalia, Ilva, Indesit-Hotpoint, Eni, Acea, Procura di Torino, Procura di Bologna. His main area of interest is at the crossroad of cultural-historical psychology with interaction design.

ISCOME 2015 ROUNDTABLE PANELISTS

Debra Roter

Debra Roter is a University Distinguished Service Professor in the Department of Health, Behavior and Society of the Johns Hopkins Bloomberg School of Public Health (USA). She has studied the dynamics and consequences of patient-provider communication for more than 35 years and has published over 250 journal articles and two books on the subject. She is the author of the Roter Interaction Analysis System (RIAS) developed as method of process analysis applied to audio or video recordings of medical encounters which has been widely adopted by researchers, both nationally and internationally. Her research includes basic social psychology research on interpersonal influence and applied research in the areas of medical education, patient activation and health services. Recent work has focused on the influence of racial and gender bias on the interpersonal aspects of medical care delivery and its impact on quality of care and health outcomes. Prof. Roter has been recognized by the Web of Science as among the most highly cited authors in the social sciences.

Brian Spitzberg, Ph.D.

Brian H. Spitzberg received his Ph.D. in Communication Arts & Sciences at the University of Southern California in 1981. He is currently Senate Distinguished Professor in the School of Communication at San Diego State University. He is the 2011 honoree of the National Communication Association Larry Kibler Memorial Award, and in 2009 he received the Western States Communication Association Scholar Award for lifetime contribution to the discipline and association. His 1994 coauthored book The Dark Side of Relationship Pursuit: From Attraction to Obsession and Stalking, won the biennial International Association for Relationship Research Book Award in 1996. He is author or coauthor of over 100 scholarly articles and book chapters, and has coauthored or co-edited several scholarly books on communication competence, communication skills assessment, and the dark side of communication. His primary areas of research involve interpersonal communication skills, meme diffusion, conflict, aggression, and stalking.

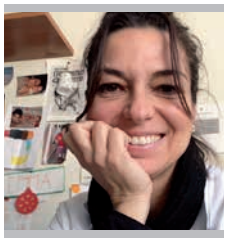
Brian Stafford

WHO Patient for Patient Safety Champion in Australia. I work with the Cochrane Collaboration in the capacity of a consumer referee to comment on the plane language sector of material prior to publication. A consumer member on the Steering Committee of Australian Resuscitation Outcomes Consortium, (Monash University – Melbourne) looking at recover rates after [our] out of hospital cardiac arrest. -- One of the UK researchers in this research project received an award in 2015 for excellence for his work on this project. I sit as the lay male member of the Human Research Ethics Committee of the Sir Charles Gardiner Hospital. I have been appointed to sit on a number of Federal (Australia) Medical Services Advisory Committees (MSAC) represented the patient's point of view.-- New medications or medical procedures that seek to be included under the subsidised medicine (PBS) have first to be submitted to a MSC committee who then makes a recommendation to the Office of the Minister of Health. Representing the community I sit with the St John Ambulance (WA) on their Clinical Quality Improvement Committee.

Richard L. Street, Jr

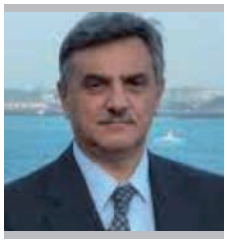
Richard L. Street, Jr. PhD, is Professor of Communication at Texas A&M University and Professor of Medicine at Baylor College of Medicine. His research focuses on clinician-patient communication, pathways linking communication to improved health outcomes, and strategies for increasing patient involvement in care. He has published over 150 articles and book chapters, as well as a number of books, monographs, and special issues of various journals. In 2003, he was named Outstanding Health Communication Scholar by the International Communication Association. In 2008, he received the L. Donohew Health Communication Scholar Award from the University of Kentucky. In 2010, he was awarded Texas A&M Association of Former Students Distinguished Achievement in Research Award. In 2012, he was given the George L. Engel award by the American Academy on Communication in Healthcare for career contributions to the research practice, and teaching of effective healthcare communication skills.

ISCOME 2015 ROUNDTABLE PANELISTS



Elena Vegni

Elena is Associate Professor of clinical psychology in the Department of Health Sciences at University of Milan. She holds a 4-yrs degree in Philosophy, a 5-yrs degree in Psychology and a training in Psychotherapy. She teaches medical students at the University of Milan, School of Medicine and she also serves as Chair of the Clinical Psychology Unit at San Paolo Hospital with a special interest on group education and counseling for patients affected by physical illnesses (e.g., oncological patients).
Elena's academic work has focused on clinician-patient communication, patient education and patients' illness experience. She is an expert of interaction analysis processes, and in particular she has been trained by D. Roter in the use of the Roter Interaction Analysis System. She has experience also in qualitative research, in particular on the principles of Interpretative Phenomenological Analysis. She is author of several national and international articles published on journals such as Patient Education and Counseling, Journal of Health Psychology, Minerva Medica and Medical Education. She co-authored of a book titled "The patient centred medical consultation", published by Cortina, Milan, Italy.



Franco Vimercati

Director of "Struttura Complessa di Radiologia" since 01/10/2000 – Head Physician qualification achieved in 1989 – Incumbent President of Federazione delle Società Medico-Scientifiche Italiane (F.I.S.M.). Teacher and Speaker in more than 100 courses and congresses on Radiology topics. Member of the Team created by the Health Ministry for "Paperless" procedures development in healthcare (CNIPA Technical Committee). Team Member of COTE Project managed by Agenas and Member of TTRAM Group created by Lombardy Region on Health Technology Assessment strategies. Elected in 1996 in the Executive Board of the Italian Society of Medical Radiology (SIRM), maintains membership as President of the National Union of Radiologists (SNR). Member of the National Committee for Continuous Medical Education (ECM) from 2002 to 2006. As Scientific Committee Coordinator has developed the CIRM Course 187/2000 of Lombardy Region on Protection against Radioactive emissions; the course has been attended by more than 5000 participants in 2007/2008. Member of the Study Group on screening procedures implementation according to DCR 1294 (29/07/1999) organized by Lombardy Region. Has developed exhaustive skills in management of criticalities related to technical choices in health management. Skills in Radiologist activities evaluation systems at national level and member of several SIRM Regional Sections focused on clinical Guide Lines development.

Albert W. Wu

Albert W. Wu is Professor of Health Policy & Management at the Johns Hopkins Bloomberg School of Public Health, with joint appointments in Epidemiology, International Health, Medicine and Surgery, and the Carey Business School. His research and teaching focus on patient outcomes and quality of care. He is director of the Johns Hopkins Center for Health Services & Outcomes Research, the PhD in Health Services Research, and the Certificate program in Quality, Patient Safety & Outcomes Research. He received BA and MD degrees from Cornell University, completed Internal Medicine residency at Mount Sinai Hospital and UC San Diego, and received an MPH from UC Berkeley. He has studied the handling of adverse events and patient safety since 1988, and has published over 370 papers on safety, quality of care and patient outcomes. He coined the term "Second Victim" in 2000, and co-directs the RISE (Resilience in Stressful Events) staff support program at the Johns Hopkins Hospital and for the Maryland Patient Safety Center. He was a member of the Institute of Medicine committee on identifying and preventing medication errors, and was Senior Adviser for Patient Safety to WHO in Geneva. He is a core member of the Armstrong Institute for Patient Safety, and Associate Editor for the Journal of Patient Safety. He edited the Joint Commission book "The Value of Close Calls in Improving Patient Safety, and is a member of the National Quality Forum Patient Safety Standing committee. He maintains a clinical practice in general internal medicine. On Twitter he is @withyouDrWu

ISCOME 2015 WORKSHOP INSTRUCTORS

Sara Albolino

Sara Albolino is patient safety manager at the Centre for patient safety of the Tuscany Region where she have been working since 2004. She coordinates regional programs on training, patient safety practices, anticipation of risks. She received her phd in Organization Sciences at the University of Milan and attended an advanced course on clinical risk manager. She teaches patient safety and reliability of systems in many academic courses and masters. She is author of many publications in national and international scientific journal. She is member of the Italian Ergonomic Society where she covers the role of International Affair Secretary and she is the Technical Chair of the International Ergonomic Association on Healthcare Ergonomics.

John Øvretveit

Dr. John Øvretveit is Director of Research and Professor of health care innovation implementation and evaluation at the Medical Management Centre, The Karolinska Institute, Stockholm (http://ki.se/en/people/johovr). Dr. Øvretveit's work is based on the belief that organisation and management can bring out both the best and the worst in us, and that the right organisation design is critical for effective healthcare. A theme underlying his work is how practical research can contribute both to better care for patients. Much of his work uses different social sciences to explain and predict events and processes in health care and clinical practice. He was awarded the 2014 Avedis Donabedian international quality award for his work on quality economics and has carried out research and practical projects internationally on quality and safety improvement and implementation since 1985. Translations of some of his 300 peer-reviewed scientific papers and books have been made into nine languages. Six books have won publications awards, including twice winner of the European Health Management Association Award and the Baxter health publication of the year prize, for "Action Evaluations" (2002) and "Health Service Quality" (1992). He is currently a reviewer for and editorial board member of eight scientific health journals, and a board member of the Joint Commission Resources/International, advisor since 1995 to The Netherlands Health Service Research Council.

GiulioToccafondi

GiulioToccafondi is a Patient Safety Manager at the GRC Patient Safety Centre of Tuscany where he is in charge for patient safety in integrated care and coordinates implementation studies for patient safety practices. He holds a PhD degree in Interaction Design and Human Factors from University of Florence. He was a postdoctoral research fellow at the Communication Science Department of University of Siena. He collaborated with national agencies on the application of Human Factors and Interaction Design for web applications and workplace learning. He contributed as a project manager and scientific coordinator to EU research in the field of communication in health care systems and learning.

Albert W. Wu

Albert W. Wu is Professor of Health Policy & Management at the Johns Hopkins Bloomberg School of Public Health, with joint appointments in Epidemiology, International Health, Medicine and Surgery, and the Carey Business School. His research and teaching focus on patient outcomes and quality of care. He is director of the Johns Hopkins Center for Health Services & Outcomes Research, the PhD in Health Services Research, and the Certificate program in Quality, Patient Safety & Outcomes Research. He received BA and MD degrees from Cornell University, completed Internal Medicine residency at Mount Sinai Hospital and UC San Diego, and received an MPH from UC Berkeley. He has studied the handling of adverse events and patient safety since 1988, and has published over 370 papers on safety, quality of care and patient outcomes. He coined the term "Second Victim" in 2000, and co-directs the RISE (Resilience in Stressful Events) staff support program at the Johns Hopkins Hospital and for the Maryland Patient Safety Center. He was a member of the Institute of Medicine committee on identifying and preventing medication errors, and was Senior Adviser for Patient Safety to WHO in Geneva. He is a core member of the Armstrong Institute for Patient Safety, and Associate Editor for the Journal of Patient Safety. He edited the Joint Commission book "The Value of Close Calls in Improving Patient Safety, and is a member of the National Quality Forum Patient Safety Standing committee. He maintains a clinical practice in general internal medicine. On Twitter he is @withyouDrWu

ISCOME 2015 "TOP PAPER" PANELS

TUESDAY, JUNE 16th

TOP PAPER PANEL

Chairs: Annegret Hannawa and Tommaso Bellandi

Using patient safety climate, employee engagement, and patient satisfaction to identify unit risk: a novel approach to adaptive organizational risk assessment

Authors: L.A.Paine, E.L.Daugherty Biddison, M.Leslie, C.Woodward, D.Miller, P.S.Kent, P.J.Pronovost, S.J.Weaver
Johns Hopkins Medicine, USA

Abstract

Rationale: Measuring patient safety climate, employee engagement and patient satisfaction has become an industry standard for US hospitals. This is largely attributable to regulatory requirements, National Quality Forum best practices, pay-for-performance programs, as well as competition to recruit and retain a strong workforce. Despite the abundance of data on these indicators, they have often been considered independently and patterns among them have not been well explored. Little is known about whether together, they can help identify organizational-level safety risks.

Research questions/hypothesis: Our objectives were to: (1) qualitatively examine similarities and differences between unit-level safety climate, employee engagement and patient satisfaction indicators, (2) define high performance and low performance thresholds for each indicator, (3) identify unit-level patterns among these indicators to facilitate prioritization of focused organizational interventions and (4) provide structured feedback to leaders about potential adaptive organizational risk.

Methods: Based on evidence and practice, high and low performance thresholds for each indicator were identified. Unit level data from five US hospitals in a large urban health system were compared using the defined thresholds and patterns were identified. A process for providing feedback on high and low performing work areas to organizational leaders was pilot tested.

Results/discussion: Results identified 1-19 unit(s) in each hospital with patterns of high and low performance on the three dimensions. This strategy uniquely provides leaders with a comprehensive picture of adaptive organizational risks. Using this novel multi-indicator approach with existing data may offer new insight into latent adaptive organizational risks related to safety climate, employee engagement, and patient satisfaction.

Patient participation and medication discussion: exploring differences in patient, medication, and information characteristics

Authors: M.Gerlander, T.Kettunen, T.Kivinen
The Univeristy of Tampere, Finland

It is estimated that only 50% of patients adhere to their medication instructions and that the treatment of chronic illnesses is often interrupted as a result. Numerous studies have identified relational and communication problems between health care providers and patients around medication as an underlying cause of poor adherence to treatment. This problem poses a threat to patients' use of their medication safely.

We explored patients' participation in treatment discussions with health care practitioners and their perceptions of discussions about medication. The main research goals were to examine how patient-reported evaluations of participation in medical treatment discussions and medication discussions differ by characteristics of patient, medication, and information on treatment.

As part of a larger development project on patient safety, a pilot survey was conducted among patients attending second and primary care units of the Central Finland Health Care District. The study group was comprised exclusively of patients who were prescribed medication (N=406) and participation was totally voluntary. The questionnaire used a Likert-type scale (1 = poorly and 5 = praiseworthy) and included subscales of being encouraged to participate (3 items), the patients' own participation (3 items) and a medication discussion (5 items). The background variables included age, gender, education, the domain of care, category of medication, necessity of medication, trust in information, and information-seeking. The subscales had strong internal reliability (Cronbach's $\alpha = 0$ .93, 0.82 and 0.90). Relationships with background variables were assessed with an analysis of variance.

The findings suggest that older patients have significantly lower evaluations in both subscales of participation. In discussions about medication, patients who were older and male expressed their concerns or fears differently than patients who were younger and female. Patients with long-term medication evaluated their own participation more negatively and the medication discussion more positively compared to those with course-based medication.

ISCOME 2015 "TOP PAPER" PANELS

A socio-ecological model and PhotoStories to understand the impact of aboriginal and Torres Strait islander health workers on infant mortality outcomes

Authors: K.Watson[1], A.Cooke-Jackson[2], J.Young[1]
[1] School of Nursing and Midwifery University of the Sunshine Coast, Australia
[2] Emerson College, Boston, MA

Abstract
Rationale: Sudden unexpected death in infancy (SUDI) is four times higher for Indigenous Australian babies compared to non-Indigenous babies1. Public health safe sleep messages were developed for mainstream society, with little consideration of cultural complexities which impact effective implementation. Indigenous Health Workers (IHW) significantly contribute to acceptability, access and use of community health services through their role as cultural brokers2. In moving safe sleep advice to safe sleep action it is imperative that IHW voices are forefront in strategies which aim to reduce SUDI.
Research Objectives: To describe and understand how the use of PhotoStories by IHWs can capture health information within communities; and empower health-related communication messages between IHW and vulnerable families whilst shaping positive health behaviors.
Methods: This collaborative, interdisciplinary formative research will use PhotoStories3 embedded in a socioecological model (SEM) to highlight collective narratives of IHWs and high risk families while they navigate SUDI messages. SEM seeks to understand health issues in marginalized communities by using a comprehensive holistic method to understand ways to engage, empower and support communities. PhotoStory involves participant-produced photography which gives agency to communities by allowing them to tell their stories through the underlying issues that are represented in the images. This approach offers an Indigenous perspective to understand ways in which health care workers using technology can advance health behaviors used by vulnerable families.
Results: It is anticipated that capturing interactions between IHW and families via PhotoStory will encourage a new narrative whereby IHW and families reframe health behaviour meanings and messages to reduce SUDI risk behaviours.
Implications/conclusions: PhotoStory, embedded in a socioecological model, will enable families to visualise the nuanced dynamic of real life behaviour to reinforce lasting lifestyle changes, and highlight the integral role of IHW as educators and cultural brokers who foster long-term community resilience and improved health outcomes.

Partnering with patients to identify and address breakdowns in care

Authors: K.Smith, T.Gallagher, K.Fisher, K.M.Mazor
MedStar Health Research Institute, USA

Abstract
Rationale: Many patients "suffer in silence" when they suspect a breakdown in communication or medical care, fearing repercussions, or not knowing who will listen.
Hypothesis: "We Want to Know", a program employing active outreach to patients' to encourage them to speak up about their concerns and providing a real-time response, will improve a hospital's ability to detect, address, and learn from patient perceived breakdowns in care.
Methods: Three medical surgical units in two hospitals (6 units total) participated in a pilot from June to December 2014. Program components include patient interviews, brochures, and a patient reporting hotline. Real-time response navigators interviewed randomly selected patients during their hospital stay or 7 to 30-days post-discharge. Navigators sought to resolve breakdowns identified during the interview and engaged unit support as needed. Significant breakdowns were entered into the patient safety event reporting system and received a system-level investigation and response.
Results: A total of 860 interviews were completed with 95% of interviews conducted directly with the patient. Patients were predominantly female (58%) with 75% of patients 51 years of age or older. Approximately 39% (n=336) of patients interviewed perceived a breakdown in care. Communication issues represented the highest frequency breakdown reported (n=180; 20.9% of patients interviewed). Delays in treatment, pain management, and medication errors were commonly cited breakdowns. For patients reporting at least one breakdown in care, harms including emotional distress, damaged patient-provider relationship, physical harm, life disruption, additional care, and financial costs were perceived, 84% were considered preventable. Outstanding problems were resolved at the time of the interview or immediately after (n=228; 83%). Thirty-nine events reported required further follow-up and 19 received an investigation and system-level response.
Implications: The We Want to Know program was effective at detecting patient concerns and provided a means of addressing and resolving problems in real-time.

ISCOME 2015 "TOP PAPER" PANELS

TUESDAY, JUNE 16th

TOP STUDENT PAPER PANEL

Chairs: Annegret Hannawa and Tommaso Bellandi

Clinicians' engagement and preferred communication route for receiving patient safety feedback: a survey study

Authors: M.Faquer-Manhaes[1,2], J.Benn[3]
[1] Faculty of Medicine, Imperial College London, London, UK
[2] National Reporting and Learning System, UK
[3] Centre for Patient Safety and Service Quality, Imperial College London, London, UK

Abstract

Rationale: Lack of effective feedback is often mentioned as a barrier for incident reporting, though there is little relevant and recent data to support the design of more effective mechanisms. Social media may offer a means of disseminating feedback from analysis of patient safety incidents whilst fostering inter-professional dialogue, but little is known about clinicians' preferences for engaging with this technology for patient safety.

Research questions We aimed to survey clinicians to determine the extent to which they engaged with existing patient safety feedback and their preferences for receiving feedback from national incident reporting.

Methods: Cross-sectional on-line survey of 84 anesthetists and surgeons of a London (U.K.) hospital (35.9% response rate).

Results: From a range of 1-8, respondents preferred to engage with electronic form of feedback: mean = 6.17 (SD 2.0); as such E-mail, mean = 6.87 (SD 1.5). Telephone, mean = 2.21 (SD 1.6), and open access Web2.0 platforms, mean = 2.76 (SD 1.9), the least favorite routes. Electronic patient safety network engagement was low, mean = 3.04 (SD 2.44). Respondents were more inclined to agree with: "I would sign up to a clinicians only social media platform" and "If one was available, I would install a safety feedback app". Experienced clinicians declared to be more aware when a national safety feedback is issued (PC 0.287, Sig.(2-tailed) 0.007); more recent qualified clinicians preferred feedback delivered to a smart phone app (PC -0.341, Sig.(2-tailed) 0.001).

Discussion: The results suggest that effective feedback may be achieved if delivered by assorted mechanisms. Recent qualified clinicians are less assured knowing when feedback is issued and more likely to engage with such feedback through Smartphone apps. Nearly two-thirds of medical students and a growing number of trainees regularly use social media. Clinicians' only Web2.0 tools and apps should be further explored as routes to disseminate feedback.

Nurses' views of patient participation in nursing care

Authors: G.Tobiano[1], T.Bucknall[2,3], A.Marshall.[1,5], J.Guinane[2], W.Chaboyer[1,5]
[1] Centre for Health Practice Innovation, Griffith Health Institute, Griffith University, Gold Coast, Australia
[2] School of Nursing and Midwifery, Deakin University, Victoria, Australia
[3] Alfred Health, Victoria, Australia
[4] Gold Coast University Hospital, Queensland, Australia
[5] National Centre of Research Excellence in Nursing Interventions for Hospitalized Patients, Griffith Health Institute, Griffith University, Queensland, Australia

Abstract

Rationale: Nurses have frequent contact with patients, highlighting their potential role in enabling patient participation, a core concept of patient-centered care. However, some nurses' actions, attitudes and communication patterns act as barriers to achieving patient participation. This is alarming given patients may help prevent hospital errors when they actively engage in their care.

Research questions/hypotheses: What are nurses' views of patient participation in nursing care?

Methods: In this interpretive study, twenty nurses were recruited from four medical wards, located in two Australian hospitals. In-depth semi-structured interviews were conducted and analyzed using content analysis.

Results: Five categories emerged from the nurses' views. First, acknowledging patients as partners showed nurses respected patients as legitimate participants, who could share knowledge and make choices. Second, managing risk emphasized nurses need to monitor participation with patients to ensure rules and patient safety was maintained. Third, enabling participation demonstrated nurses' verbal strategies which enhanced patients' participation including relating, motivating and informing patients. Fourth, hindering participation encapsulated nurses' difficulty in engaging patients with certain characteristics. Finally, nurses realized participation as patients being involved in physical activities or clinical communication. For clinical communication, nurses believed patients could verbally help ensure their own safety.

Discussion/implications/conclusions: Nurses have a crucial role in promoting patient participation, which can be facilitated by acknowledging and verbally enabling patients. The nurse's role in enacting participation is complex, having to accommodate each patients risk and characteristics. Nurses need to

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reflect on their own practice to ensure they act in a patient-centered manner. This study also highlights the importance of teaching effective nurse-patient communication skills such as being patient-inclusive, building rapport and sharing information. When nurses effectively engage with patients, patients may be able to improve safety through communication.

Engaging large audiences in conversation about cancer research: a case of social media efforts

Author: Y.Strekalova, J.Krieger
University of Florida, USA

Abstract

Rationale: Health literacy and active seeking of information have been linked to positive health outcomes by numerous research studies. Research shows that active engagement in information exchange leads to increased levels of health empowerment and self-efficacy. Effective dissemination of information about health and research-based evidence to and active dialog about these topics with audiences can be achieved through social media. Social media provide a platform for rich media exchange in a variety of forms which may include text, video, and images. The goal of this study was to assess the effectiveness of social media communication efforts aimed at information exchange about cancer-related research.

Research Questions

RQ1: What are the differences in audience engagement by the type of post?

RQ2: What research-related posts are more effective in engaging the audience in active communication?

Method: Posts on the Facebook page maintained by the National Cancer Institute and associated meta-data were downloaded for analysis. Included posts had dates between 2010 and 2014. In total, 1,979 posts generated 4,537 comments, 77,298 shares, and 145,462 likes. The data were non-standard and could not be transformed. Therefore, non-parametric statistics were used to explore and identify significant differences. Posts and associated comments were collected automatically in an Excel file and coded as research or non-research based on the presence of predefined keywords.

Results: Overall, photos, followed by links to stories, were the most popular type of content among all audience groups. Most of research-related posts were links. However, photos attracted significantly higher levels of audience engagement. Among links, links with shorter descriptions were significantly more likely to received comments, shares, and likes.

Implications: The results of this exploratory empirical study show that large audiences can be actively engaged through social media. However, the modality of shared information plays an important role in attracting attention and engagement.

Breaking bad news – a challenge for the doctor's interaction

Author: M.Artkoski, M.Hyvärinen
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Abstract

Interpersonal communication has a central meaning in a medical doctor's work. Research indicates that skilled interaction between a doctor and a patient has connections e.g. to a good outcome, treatment motivation, and the patient's satisfaction (Street Jr. et al. 2009). There are special challenges regarding interaction in a situation where the doctor has to tell bad news (BBN).

BBN has been elaborated both from the perspective of a doctor and a patient in quantitative research literature (Fujimori & Uchitomi 2009). The results emphasize essential communication skills, adaptation to each patient's situation, salience of emotional support and training of communication skills. For instance, different patterns for BBN have been generated (Buckman 2005; Sparks et al. 2007; Villagran et al. 2010) based on previous research. Qualitative research in the speech communication field concerning BBN and doctor's subjective experiences is scarce.

In this qualitative study, 28 doctors from different health care sectors were interviewed. The semi-structured interviews focused on revealing the diversity of BBN and on increasing the understanding of challenges in doctor-patient interaction.

The research questions were:

1) What kind of subjective experiences do doctors have from BBN?

2) How do doctors disclose bad news?

3) What particulars do impede doctors' interaction in BBN?

The results show doctors experience BBN as challenging tasks and these situations as emotionally burdensome. How the bad news is told, is on the one hand connected with the meaning (i.e. factual aspect) and on the other hand with the patient (i.e. relational aspect). The interaction shows tensional contradiction: doctor's truth telling intertwined with the aspiration to either protect himself or the patient.

The results can be utilized e.g. in doctors' communication skills training. Further research themes concerning BBN are especially doctors' emotions, cultural competence, and listening of patients.

ISCOME 2015 ORAL PRESENTATIONS

MONDAY, JUNE 15th

Oral Presentations "Front-line experiences in quality and health care"

Chair: Laura Rasero
Respondent: Debra Roter

Learning from the frontline: Trainee-led analysis of patient safety incidents

Authors: M.Ahmed[1,2], P.Baker[1], N.Sevdalis[2,3], C.Vincent[2,4]
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Abstract

Rationale: Various factors may discourage formal incident reporting amongst junior doctors (trainees), resulting in missed opportunities for learning. The 'Lessons Learnt' training programme was implemented to promote trainee-led discussion and analysis of patient safety incidents (PSIs) experienced in practice, guided by a structured, validated proforma.

Research Question: This study aims to: i) describe the characteristics of PSIs brought for discussion by trainees, and ii) examine the impact of trainee-led structured analysis in terms of lessons learnt, and proposed clinical improvements to prevent future PSIs.

Methods: This was a prospective qualitative in-depth analysis of a random sample of 30 PSI proformas submitted during the 'Lessons Learnt' programme in 2011-13. Two physician reviewers independently analyzed the proformas to code incident type and outcome using the UK National Patient Safety Agency's taxonomy. Contributing factors were analyzed using the validated London Protocol taxonomy. Thematic analysis was used to analyze lessons learnt, and proposed recommendations for improvement. Disagreements were resolved through consensus, involving a third reviewer where necessary.

Results: The commonest types of incident were delay/failure to access care, delayed/wrong diagnosis, and medication errors. Incident outcomes spanned the full range of severity from 'no harm' to 'patient death'. On average, seven contributing factors were attributed to each PSI; the commonest were individual and team factors, environmental, and task/technology factors. Trainees proposed relevant actions/recommendations for improvement, targeting individual and team practices, as well as wider healthcare systems and processes. Numerous lessons were drawn from the case discussions, with the majority relating to improving personal practice: 'advocate for patients' and 'be vigilant'.

Discussion/Implications/Conclusions: The distribution of types of PSI brought for discussion by trainees suggests that the 'Lessons Learnt' programme uncovers PSIs currently missed by formal incident reporting systems. Structured trainee-led analysis of PSIs encourages safe practice at an individual level and may also promote wider engagement in safety improvement efforts through proposed recommendations that improve healthcare systems and processes.

U.S. health care managers' perceptions of quality: Does communication matter? Evidence from episodes of care.

Authors: R.Amati, A.Hannawa, A.Kaissi, T.Bellandi, R.Brook
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Abstract

Rationale: In his ground laying framework, Donabedian (1966) conceptualized quality care as a construct consisting of structure, process and outcome. In 1970, Sanazaro and Williamson conducted a national study in the United States to identify how physicians descriptively characterize good and poor quality care. Given that healthcare managers make decisions on quality initiatives, we replicated Sanazaro and Williamson's methodology, focusing on healthcare managers' perspectives with a specific interest in examining whether 45 years later, communication would emerge as a component of quality care.

Research questions: What indicators of structure, process and outcomes do healthcare managers identify as characteristic of good and poor quality care? What role does communication play in their quality conceptions?

Methods: 236 healthcare managers who graduated between 2004 and 2013 from the Healthcare Administration program at Trinity University (Texas) were asked to complete an online survey. Respondents described one good and one poor quality episode that they had experienced within the past three years. In response to three open-ended questions, they explained (1) what happened during each episode, (2) what circumstances made it either good or poor in quality, and (3) what the consequences were for the patient. Each episode was thematically analyzed by two researchers to identify emerging categories of quality care.

Results: 74 managers provided 135 episodes of care (response rate = 33.4%). The analysis of the episodes yielded a total of 793 statements related to structure, process, outcome, but also context – which appeared as an additional factor to consider. Out of all descriptions, 9% (n=68) described structural measures of quality – including availability/lack of facility (16%), staff (46%), and organizational (38%) resources. Contextual characteristics emerged as an important factor in 7% (n=57) of all statements, particularly in relation to clinical (70%) and patient (30%) aspects. Process measures covered 52%

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(n=411) of all statements, including subcategories such as provider-patient communication (33%), inter-staff communication (27%), timeliness (10%), dedication to the profession (8%), medical performance (8%), and guidelines adherence (6%). The communication category alone accounted for 62% of all process-related descriptions. Finally, 32% of all statements (n=257) reflected good and poor outcomes. The majority of them (76%) emerged at the individual level, while the rest described outcomes related to relational (6%), institutional (12%), and societal aspects (6%).
Conclusions: Previous work recruiting care episodes to investigate quality has relied on physician samples. When describing quality, physicians primarily described care in terms of technical measures. In this investigation of health care managers, communication evolved as a major process marker of quality care. Statistics consistently evidence that healthcare lacks quality, and our findings suggest that improving quality requires communication competence interventions.

Feedback as intervention to change professional behaviour and improve the quality and safety of anaesthetic care: a mixed methods evaluation

Authors: D.D'Lima, J.Moore, G.Arnold, A.Bottle, S.Brett, J.Benn
Imperial College London, UK

Abstract
Rationale: Data feedback as a communication intervention is rarely studied and poorly understood despite its potential for supporting improvement to patient safety. This study aimed to evaluate the use of quality indicator feedback to change professional behaviour and improve the quality and safety of anaesthetic care.
Research questions/hypotheses: We hypothesised that implementing sustained monitoring and feedback of data from anaesthetic quality indicators (such as temperature and patient reported pain and nausea after surgery) would stimulate professional behaviour change and improvement in compliance with best standards of care.
Methods: Enhanced feedback consisted of monthly, personalised feedback reports containing sophisticated statistical breakdown of data and both comparative and longitudinal views. The reports were paired with an active programme of dissemination and professional engagement. The evaluation adopted a mixed method quasi-experimental design, with quantitative analysis using interrupted time series models to determine impact upon anaesthetic quality indicators and a longitudinal qualitative component to capture the experience of users.
Results: Implementation of enhanced feedback had a significant positive impact upon two post-operative pain measures, nurse-recorded freedom from nausea, mean patient temperature upon arrival in recovery and quality of recovery scale scores. Qualitative analysis of user experiences revealed interactions between context, intervention and user, demonstrating a positive response by clinicians to this type of initiative and willingness to interact with a sustained and comprehensive feedback protocol to understand variations in care and patient safety.
Discussion/implications/conclusions: Our results suggest that continuous quality monitoring and data feedback represent an effective communication intervention, where feedback is implemented as part of a complex intervention with peer support, active engagement and professional dialogue concerning how to respond to evidence of variation. This work has important implications for design of feedback that can improve quality and safety of care.

Communicating with non-speaking patients: a survey of current practices in Swiss intensive care units

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[3] Intensive Care Unit, Kantonsspital Graubünden, Switzerland

Abstract
Rationale: Communication with critically ill patients is essential to ensure effective and safe care. In intensive care units (ICUs) communication is particularly challenging: non-speaking patients (NSP) experience drastic impairment in verbal communication due to physical reasons despite being fully awake. This study explored current communication practice with NSP in Swiss ICUs.
Methods: On the basis of semi-structured interviews we generated and distributed a 20-item online-questionnaire to 836 Swiss ICU clinicians. We ran descriptive and correlation analyses.
Results: Response rate was 70% with 448 nurses, 95 physicians, 41 unspecified. Communication with NSP was described as frequent (75%) and time-consuming (75%). A total of 82% perceived communicating with NSP as difficult or frustrating for both patients and health care providers. Ineffective communication results in patient agitation (89%; significantly related to clinicians' frustration (.114**) or lack of training; .093*). Patient assessment was perceived as inaccurate (71%) and may result in inadequate sedation (62%) or analgesia (56%).
Current communication strategies are: yes/no-questions (88%), interpreting mimic (81%) and lip reading (69%). Further help was sought in Assisted and Alternative Communication (AAC) tools (65%), involving relatives (64%) or colleagues (56%). Analgesia (17%) or sedation (13%) was used as a strategy particularly when communication was described as difficult (.132** and .130**, respectively). Strategies to learn about NSP communication were trial-and-error (79%) and observing colleagues (73%). Past theoretical training (44%) correlated negatively with experienced difficulties (-.102*) and positively with the use of various AAC-tools.

Conclusions: This study identifies relevant challenges in communicating with NSP in ICUs. Increased level of frustration, inadequate use of sedation and analgesia, time consuming and still ineffective attempts in communication with NSP reveales a relevant need for improvement in communication strategies. Effective support via training and AAC-tools may contribute to improved quality and safety of care.

Oral Presentations "Innovations for healthcare quality and safety"

Chair: Pascale Carayon
Respondent: Antonio Rizzo

Using automated text analysis to analyze data

Authors: M.Rosen, E.Kasda, M.Leslie, A.Dietz, C.Xinxuan
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Abstract

Rationale: Safety event reporting is a fundamental mechanism of learning in high reliability organizations. It provides a mechanism to identify and mitigate risks. Yet, there are challenges to getting the most out of event reporting data. The volume of narrative data can be overwhelming. It is difficult to aggregate and identify trends that can be used to set priorities and allocate limited resources for learning and improvement. Additionally, the current taxonomy for coding data has limitations making it difficult to identify trends, and the 'end user' of the system responsible for coding.

Research Question: Our work applies cutting edge methods for automated text analysis to augment existing practices of synthesizing event reporting data. Topic modeling is an approach to generate themes within large sets of data. Using this approach, we are building new ways of analyzing, organizing, and visualizing event reporting data. Our ultimate goal is to improve the identification of patterns so that learning and risk mitigation are made more efficient.

Methods: Eighteen months of event reporting data was analyzed for a large urban academic medical center.

Results: Results indicate that a relatively small number of topics can describe a large portion of the data. These themes are logically coherent and meaningful.

Discussion: By building a system capable of analyzing submitted event reports based on themes within the narrative report, we achieve three core advancements. First, we reduce the amount of resources needed for coding the data. Staff time is at a premium, and can be better spent following up and addressing safety issues. Second, we gain a categorization system capable of generating more useful insights into the data. Third, we produce a quantitative method for analyzing narrative event reports that can be combined with other data sources to better understand potential risk.

Mandatory presuit communication and mediation

Authors: R.C.Jenkins, K.Aasheim
JHMHC Self-Insurance Program, USA

Abstract

Rationale: In the United States annually, $76 billion to $126 billion are spent on medical malpractice litigation, which is often related to patient dissatisfaction with provider communication. Traditional litigation also exposes patients and providers to unnecessary anxiety, lengthy delays, and many other uncertainties. The University of Florida Health System (UF Health) has effectively reduced these impacts by 75% over 7-plus years, utilizing the Florida Patient Safety and Presuit Mediation Program (FLPSMP), which requires patients to agree, upon admission for treatment, to attempt confidential, non-binding mediation communications before filing a lawsuit.

Research Questions / Hypotheses: By promoting confidential, early communication between patients and providers, presuit mediation provides fast, fair compensation for meritorious claims and increases patient satisfaction, while limiting healthcare provider costs incurred during traditional litigation.

Methods: On January 1, 2008, UF Health instituted FLPSMP, which incorporated a mandatory mediation agreement in the hospital admission informed consent process. FLPSMP resolves claims years earlier, saves thousands of dollars in legal costs, and increases average net compensation per claim by as much as 50% annually, as compared to claims resolved through litigation.

Results: More than 5 years of FLPSMP data confirm improved satisfaction in patient-provider communication, years-faster resolution of claims, lower legal expenses, and greater net compensation to deserving patients.

Discussion/Implications/Conclusion: Through structured, confidential patient-provider communication, the FLPSMP mediation process creates opportunities to resolve conflict promptly, without litigation, where high costs may reduce net recovery. The FLPSMP process also enhances patient safety, enabling providers to learn from potential claims and implement improvements years earlier. Systematic implementation of FLPSMP has produced a template for replication beyond Florida, empowering providers and patients nationwide to realize the benefits of mandating mediation communication as a preferred alternative to medical malpractice litigation.

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Language technologies for automatic readability assessment of health-related Information: a preliminary investigation into the informed consent forms used in a regional health service

Authors: G.Venturi[1], S.Rinnone[1], S.Montemagni[1], M.Sassi[1], G.Terranova[2], E.Flore[3], T.Bellandi[3]
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Abstract

Rationale: Within an information society, where everyone should be able to access all available information, improving access to written language is becoming more and more a central issue. This is the case for health-related information which should be accessible to all members of the society, including people who have reading difficulties as a result of a low education level or of language-based learning disabilities or because the language of the text is not their native language. Moreover, the breakdown of doctor-patient communication is one of the most frequent cause of adverse events.

Research questions: We conducted a preliminary investigation to assess the readability of a corpus of informed consent forms used before a clinical procedure in the hospitals of a Regional Healthcare Service. Secondary goals include the comparison of readability across specialties and healthcare trusts.

Methods: Providing complex scientific information in a way that is comprehensible to a lay person is a challenge that nowadays can be addressed by resorting to advanced Natural Language Processing (NLP) techniques, which make it possible to monitor the linguistic complexity of texts at the syntactic and lexical levels and to support their simplification, whenever needed. The study has been carried out by combining NLP-enabled feature extraction and state–of–the–art machine learning algorithms. To this end we used READ-IT, the first NLP-based readability assessment tool for Italian.

Results: We analysed 584 documents, covering 29 specialties, for a total of 607.790 word tokens, currently used at the 36 public hospitals in Tuscany. Although the readability level of all documents in the corpus is low, both at the lexical and syntactic level, significant differences can be observed between specialties and healthcare trust releasing the forms. With the readability level ranging between 0 (easy-to-read) and 100 (difficult-to-read), it resulted that the pediatric informed consent documents are the most easy-to-read forms (with an average score of 75) while the most difficult-to read documents are documents of the surgical area (whose average score is 80) (standard deviation 2).

Discussion: The state of the art resulting from this preliminary study shows that NLP-based readability assessment tools can help to measure the linguistic complexity of informed consent forms and guide the editor to identify linguistically complex passages that need to be simplified, either syntactically or lexically. The use of an assessment tool designed for the general language is the main limitation of the study and should be addressed through the customization of the tool to assess the readability of the healthcare jargon. A further step of the research consider also the design of a guidance to prepare readable informed consent forms.

Innovative training for maternal care pathway

Authors: M.Bonciani, F.Niccolai, B.Lupi
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Abstract

Rationale: Maternal care pathway (MCP) involves many professionals of different disciplines (obstetricians, midwives, nurses, psychologists, social workers, paediatricians) at district and hospital level. This complexity, without a good level of communication and shared views and practices among them, may increase the risk of low quality results or adverse events.

Research question/hypotheses:The hypothesis is that participatory training methods, using in particular Mind Maps and Flow Charts tools, may have a fundamental role in consolidating teamwork and common vision of MCP among involved professionals.

Methods: A training course was organised in Pisa Local Health Authority (LHA), addressed to the all MCP staff, both of the Pontedera district hospital and of primary care and maternal care practices. A large majority of the Pisa LHA MCP staff attended the training course (27 midwives, 15 obstetricians, 5 psychologists, 3 nurses, 3 paediatricians, 3 other district professionals), that has been articulated in a number of sessions of small interprofessional groups. In the first step of the training course, Mind Maps and Flow Charts were used. The former concerned the individual mental representation of the MCP based on each professional's job experience and the latter were drawn by group work to retrace the MCP that pregnant women should go through in each districts until postpartum. These two tools were used and discussed within cycles of actions and reflections. Participant observation was also applied during this training process.

Results: Mind Maps analysis identified the common words occurrence and the more relevant meaning areas. The Flow Charts synthesis showed the different MPC steps, with services and professionals involved in each of them. Both outputs pointed out strengths and weak aspects of the MPC in Pisa LHA and – following the feedback given by training participants - help dramatically the professionals to consolidate a shared vision on it.

ISCOME 2015 SPEEDY PRESENTATIONS

MONDAY, JUNE 15th

Speedy presentations "Litigation; Technology; Diagnostic error"
Chair: Elena Beleffi

SP7 Clinician-patient relationship in the management of medical litigation: the experience of Lucca

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In the Regional Healthcare System of Tuscany a direct management of medical litigation operates since 2010. It is a model that allows health facilities to have a greater awareness of the critical points underlying the claims, not only managing the compensation but also offering an unmissable opportunity to prevent adverse events and to recover patients' trust.
In the system of "self-insurance" adopted by the hospital of Lucca, the direct relationship with the patient takes place essentially in the clinical examination. The medical examination has its technical goals (i.e. acquire clinical data for the assessment of the damage and the causal relationship with the conduct of healthcare professionals), but undoubtedly it also represents the key moment to create a climate of collaboration based on proper and effective communication. For this purpose it was necessary to establish specific management procedures in the relationship between patient and examiner during clinical evaluation, these procedures were based on scientific evidences and experiences gained in these years of selfinsurance.
This paper describes the current operating protocol, inspired by some basic principles such as empathy, promptness, alliance with the citizen and commitment to improvement, according to the current addresses of national and international health policies highlighting the need to develop systems that promote transparency and openness to citizens. These procedures are based on current scientific literature and are considered the best strategies from both functional and ethical point of view to improve patient safety and to reduce clinician-patient conflicts.

SP46 New approaches to claims processing - Retrospective Damage Analysis

Author: L.M.Marzi
Vienna General Hospital, Austria

Abstract
A survey conducted in 2005 analyzed all cases of malpractice since the year 2000, which had caused costs exceeding EUR 700 based on approx. 40 parameters with the assistance of the liability insurance company. The parameters included not only the age and length of service of those responsible for the damages, but also the time, weekday, month of occurrence as well as other factors such as communication or discipline-based aspects.
The typical damage case occurs to an above-average employee in a risk-prone discipline especially often between Friday and Sunday in the months January, March or July due to a preceding communication error.
1. The Legal Emergency Kit
In 2007, the "Legal Emergency Kit" was introduced in the Vienna General Hospital. It represents a handy plastic case, which is labeled accordingly and on which a section sign (§) is stamped. Every employee must be able to access such a plastic case within one minute of his/her workplace.
The legal emergency kit contains manuals on the correct behavior in the event of damage.
Eight years after its introduction, the following results can be established: Clear improvements could be registered in terms of the raising of awareness among employees with regard to proper behavior in the event of damage and critical / undesirable events are now being reported even faster than before.
2. Fast accessibility of legal aid in delicate situations
The quickly accessible legal assistance (also during the weekend) is held in very high esteem by the hospital employees. It means improved security, which ultimately benefits the patient.
The damage statistics of AKH Vienna since the year 2000 shows a clear (more than 50%) reduction of the number of cases and also a decrease in the amount of damage claims payments.

SP50 Safe Surgery on line: Web application for documentation, dissemination and self-assessment of best practices in surgery

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Coordinatore TIISO (ACOI, AICO, AIIC, SIAARTI, SIC), Italy

Goals
1) Spreading the culture of quality and security in surgery based on methodology and evaluation of results
2) Support professionals for continuous improvement in BO and U.O. surgery
• Multidisciplinary : surgeon , anesthesiologist , nurses , risk managers
• Systematic : in the objectives and method

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• Conforms to national requirements and international state of the art
• Implementing, flexible and sustainable
3) Contents and Tools
• Documentation of 32 Best Practices prepared by multidisciplinary committee
• Knowledge Base queried online and constantly updated
• Capability assessment and periodic monitoring, reporting and benchmarking
Views
1) Prompted Query to-date knowledge base
• Documentation of Best Practice (BP)
• Clinical, organizational and technological aspects
• Process mapping, professional profiles and objectives ministerial
• Periodic update
2) Mapping process and organizational analysis
• Mapping of security requirements compared to 85 critical activities
• Correspondence with the objectives of the ministery and WHO
• Census of BP adopted
• Organizational analysis on how to take BP
• Benchmarking between U.O. and / or structures
3) Monitoring and evaluation of the safety in surgery
• Minimum BP
• Monitoring campaign of BP based on indicators of process and outcome
• Longitudinal analyzes (continuous improvement)
• Benchmarking between U.O. and / or structures
• Reporting pre configured
Web-application functionality
• Campaigns Monitoring Best Practices adopted through a dashboard of indicators and reporting preconfigured
• Realize at the aggregate level (associative-regional-national) gap analysis and benchmarking
• Access to updated and validated information on the requirements and procedures for implementation of BP
• Self-assess the degree of compliance with organizational and process the safety objectives ministerial
• Self-assess the degree of compliance with the requirements of clinical and organizational BP documented and evaluated

SP9 Online Guided Checklist (OGC): human factor and technology supporting the culture of teamwork

Authors: G.Cafarella[1], F.Venneri[2], G. Giaconia[1]
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Abstract
Rationale: According to literature, teamwork, participation, agreement and communication represent strategic aspects within multidisciplinary and multitasking processes. Nevertheless in healthcare cultural and educational gaps among stakeholders associated to the difficulty in measuring outcomes instantaneously cause inefficiency and inefficacy within these processes and yield malpractice issues and claims.
Research Hypothesis: OGC methodology and approach has the goal of planning and measuring complex healthcare processes associated to the humanization of these by means of a measurable "value" combined to the implementation of participation, agreement and solidity.
A combination of human factors, technology and particularly artificial intelligence has the objective to enclose the human being and "machine learning" on a double-track basis, therefore regarding stakeholders, knowledges, competences, skills, information, training focused on the implementation and improvement of communication by measuring and optimizing its value in an automatic and continuing manner.
Methods: The A.O dei Colli Healthcare Service – Naples in 2014 proposed and began a multicentric observational study using the OGC platform. This project was also approved by the Italian Ministry of Healthcare among the CCM 2013 Institutional National Projects Proposals. This study began in October 2014 and will end in June 2015. 22 Surgical units throughout Italy have been enrolled and many healthcare professionals of the field of surgery are testing the platform on the perioperative phase of the process. The ICT application consists in registering the patient submitted to a defined surgical procedure and check that all items concerning quality and safety are assured. This is performed according to the principles which inspired the diffusion of the WHO Surgical Safety Checklist; OGC combines the items of the checklist and machine learning approach.
Discussion/Implications/Conclusions: The added value of this methodology is the actual measurement of a determinat (value) in the quality and safety process. The aim is to analyize data regarding time, communication and workload and propose implementation issues to improve teamwork and all clinical governance principles. It may evidence how technology and human factors combine to assure patient safety and organizational improvement.

ISCOME 2015 SPEEDY PRESENTATIONS

SP48 Communication and safety: all in one click

Authors: A.Molisso, E.Barbanti, E.Chisci, L.Ercolini, P.Frosini, S.Michelagnoli, E.Romano, N.Troisi
Azienda Sanitaria Firenze, Italy

Abstract

Care continuity is a basic point for high quality healthcare processes.
We can say that care continuity is a continuous string of step in which are involved many professional actors moving in a care setting.
In hospitals, handoffs are episodes in which control of, or responsibility for, a
patient passes from one health professional to another, and in which important information about the patient is also exchanged.
The lack of effective communication is a contributing cause for several sentinel events that occurred from 2009 to 2011 in the USA (Horowitz 2008, The Joint Commission 2011) and for adverse events in the UK. Many studies demonstrate how poor communication during the exchange of medical information contributes to handover incident and inefficacy of care processes. The modalities used to deliver medical information are important for patient safety in healthcare systems.
In this new era, healthcare providers are driven to find new ways to cut costs while improving care. To meet these challenges, healthcare organizations have thought to a new view of information technology. After decades of paper based hospitals, healthcare is turning to information systems to manage patient data and control costs, improve overall efficiency and enhance patient care.
Methods: ARGOS is an electronic patient record system that improves handover by eliminating errors due to handwriting, allows, when necessary, to rebuild a patient history and to visualize diagnostic exam and vital parameters of patients
Conclusions: After a clinical and computerized experience lasted for at last 10 years the Authors come to the conclusion to keep on developing a new computerized instrument built with the aim to look after the patient from the first contact in the office, during all the pre operative period (preoperative evaluation), informed consent, hospitalization, surgical intervention, post operative care (drugs and nurse management) and follow up. All these phases are linked in our systems in a continuum of information generated in all the phase of the clinical pathway working on this workflow technologies. All these information contribute to generate a more reliable clinical chart with the involvement of all the actors like surgeons, anaesthetist and nurses.
True automated management of patient records is now available through patient data management systems.

SP36 Communication strategies for Venous Thromboembolism (VTE) Prophylaxis

Authors: P.Hoonakker, P.Carayon, R.Cartmill, A.Schoofs Hundt, L.Grepo, Y.Li, J.Stamm, K.Wood
University of Wisconsin-Madison and Geisinger Health System, USA

More than 15 years ago, the Institute of Medicine released the influential report: To err is human. The report and subsequent research pointed out that many patients in the USA die as a result of medical errors and that lack of consideration for human factors and poor communication are major contributing factors to patient safety.
Venous thromboembolism (VTE) is a frequent, but preventable complication for hospitalized patients that can lead to significant morbidity and mortality. It has been estimated that more than 900,000 VTE cases occur in the US every year.
VTE prophylaxis remains one of the most widely recommended patient safety strategies by the Agency for Healthcare Research and Quality; however, major challenges remain in implementing interventions for preventing VTE. In this study we focus on understanding various strategies for the prevention of VTE from the viewpoint of clinicians, in particular physicians who care for various groups of hospitalized patients. We present the results of a survey among senior and junior physicians on their perceptions of barriers to VTE prophylaxis, and the effectiveness of various interventions to improve prophylaxis, including technology-based and human communication methods.
The survey was based on a study by Lloyd et al and was pilot tested; it includes questions on artifact-based (e.g. posters), technology-based (e.g., computerized alert that prompts for prophylaxis) and human communication (e.g., nurse reminders to physician about VTE prophylaxis) methods for VTE prophylaxis. Results show that healthcare providers do not believe that solutions such as posters or pockets cards will help to improve prophylaxis; that they do believe that specific technological solutions can help; but also that human communication can be effective. The latter strongly depends on who reminds the physician about VTE prophylaxis. Finally, there are also some interesting differences between junior and senior physicians. These results will have consequences for the design of a computer decision support system.

SP11 Role Network Analysis of Venous Thromboembolism (VTE) Diagnosis in the Emergency Department

Authors: P.Carayon, L.Grepo, B.Patterson, Y.Li, A.Schoofs Hundt, R.Cartmill, P.Hoonakker, K.Wood
University of Wisconsin, Madison and Geisinger Health System, USA

Abstract

Diagnostic errors have slowly come to the forefront of patient safety [1,2]; they include missed diagnosis, delayed diagnosis and wrong diagnosis, and often occur in ambulatory care settings and emergency departments (ED). About one-third of patients presenting to an ED may have a delayed diagnosis

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of pulmonary embolism (PE) [3]. The role of ED physicians is critical in the diagnostic process of PE and deep vein thrombosis (that make up VTE); however, it is important to recognize the contribution of other people in VTE diagnosis as they provide information or ask questions. In this study, we used the role network analysis methodology to identify the various people (and their tasks) involved in VTE diagnosis in the ED. Our preliminary data collection focused on interviewing 8 physicians of one ED in a US medical center. We developed an interview guide based on the Critical Decision Method [4] that captured information about the VTE diagnostic process in the ED. Using these qualitative data, we constructed a role network analysis that identifies (1) various roles involved in VTE diagnosis, (2) communication between roles, (3) individual tasks, and (4) technologies used for communication and individual tasks. In this ED, VTE diagnosis involves multiple interactions between the attending (senior) physician and the resident (junior physician) (e.g., sharing information and discussing patient situation); it also includes other ED clinicians such as nurse, physician assistant and pharmacist (e.g., reporting changes in patient status). The VTE diagnosis role network extends beyond the ED with the participation of others in imaging services (e.g., radiologist communicating test results to ED physician), laboratory and hospital. Next steps of the research project include extending the data collection and analysis to other EDs, and using role network analysis and other methods to develop sociotechnical interventions for improving VTE diagnosis in the ED.

MONDAY, JUNE 15th

Speedy Presentations "Reporting; Patient Involvement"

Chair: Elena Vegni

SP47 Effective feedback from Centralised Incident Reporting Systems in patient safety: a systematic narrative review

Author: M. Salmaan, D.D'Lima, J.Benn
Imperial College London, UK

Abstract

Rationale: Reporting and analysis of data in Centralised Incident Reporting Systems (CIRS) in patient safety is an evolving field of research, with many countries investing in national or large scale systems. There is limited understanding, however, of how best to translate information gained from such analysis into improvement and action in frontline care.

Research questions: This review aims to synthesise research on effective feedback and learning mechanisms from CIRS and gather supporting evidence on factors affecting use of interventions to support patient safety improvement.

Methods: 1350 results returned from 3 databases were reviewed using inclusion criteria, where empirical studies evaluating feedback were classified above non-empirical or non-evaluative work. Articles were synthesised systematically, drawing information on effective feedback and learning and implications for future developments, for narrative analysis. Two reviewers undertook synthesis, discussing any disagreements.

Results: 18 studies directly evaluated outputs from CIRS globally, discussing feedback type and impact of interventions. Outputs targeted to relevant staff groups, and supported by evidence were more effective in improving safety and risk. Using multiple channels to disseminate key changes results in improved awareness and change locally. A further 16 articles identified factors influencing feedback dissemination and implementation. Trialling outputs before national dissemination is favoured to minimise issues arising. Utilising feedback to engage staff with reporting and reprioritise patient safety as a core clinical responsibility was highlighted as an important function of CIRS outputs.

Discussion: The review findings give rise to several recommendations for the design of future feedback mechanisms for CIRS. The evidence base for effective forms of feedback from CIRS is currently underdeveloped when compared to similar work on improvements in reporting, notably lack of consensus on outcome measures and frameworks to create optimal outputs from CIRS. Future research should focus on developing outputs and evaluating their effect on learning locally.

SP39 The impact of staff perceptions of safety on event reporting

Authors: E.M.Kasda, L.A.Paine
Johns Hopkins Hosital, The Johns Hopkins Armstrong Institute for Patient Safety, USA

Abstract

Rationale: It has been established that adverse events are underreported, and many things can impact the culture of reporting including: shame, fear of retribution, time to report, complexity of systems, perceived value, and reporting fatigue. However, little is known about which staff perceived constructs of safety have the greatest impact on reporting.

Research Question: Safety culture surveys measure attitudes and beliefs about safety, how safety is implemented, and the structures and processes in place to improve safety. This analysis examines the relationship between reporting rates and staff perceptions of safety, for 42 inpatient units at a large urban academic medical center. The goal was to identify key predictors of event reporting.

Methods: Event reports submitted between September-December 2013 were obtained, and an ADT Index measure was used as a standardized volume of patient flow into and out of the unit for the time period. Using Poisson regression, safety culture scores for each predictor were compared to the number events reported per unit.

Results: Total number of events reported were positively correlated with higher culture scores. Key predictors included: staff are encouraged to report, and safety efforts are valuable in protecting patients. Near miss reporting was positively correlated with medical errors are handled appropriately. Harmful events were positively correlated with difficulty discussing errors, and the culture in this work setting makes it easy to learn from others.
Discussion: Patterns of event reporting are linked to perceptions of safety and vary across units, indicating that culture lives locally. In order to improve event reporting, it is essential that leaders encourage staff to report and that learning from events be communicated back to front-line staff who reported the event and will be impacted by the change.

SP18 Dissemination of data from centralised Patient Safety Reporting Systems (PSRS) to healthcare providers: a survey study

Authors: D.D'Lima, M.Manhaes, S.Mohammed, J.Benn,
Imperial College London, UK

Abstract

Rationale: Dissemination of data from centralised Patient Safety Reporting Systems (PSRS) to healthcare providers does not always result in the implementation of improvements to patient safety. This type of communication needs to be better understood and improved in order to ensure that patient safety incidents lead to effective and sustainable organisational learning.
Research questions/hypotheses: This work aimed to investigate who is currently using institutional level feedback from a centralised PSRS and for what purposes. Additionally, we aimed to describe and evaluate how effective the feedback was for those purposes and identify ways in which it could be improved.
Methods: A survey was circulated to registered users of a centralised PSRS in the UK. The survey was designed with reference to research on the characteristics of effective feedback for incident reporting. Quantitative items were measured on an 8 point Likert scale ranging from 'strongly disagree' to 'strongly agree'. Free text items were included.
Results: The survey had 320 respondents representing 49% of possible healthcare providers. Results demonstrated that feedback from the PSRS generally met organisational benchmarking needs and enabled monitoring of data quality by healthcare providers. However, feedback was not detailed or timely enough to enable information to be adapted and disseminated for other purposes. 75% of respondents indicated that both doctor and nursing groups never used institutional feedback from the PSRS. Therefore, respondents did not find the feedback useful for responding rapidly to patient safety issues and effectively supporting local improvement initiatives.
Discussion/implications/conclusions: Feedback from centralised PSRS should be communicated to healthcare providers in a detailed and timely way. It should be ensured that such feedback can be tailored for and targeted at specific clinical groups and individuals and disseminated onwards from institutional level. Future PSRS should account for how feedback can be of maximum benefit locally to support patient safety improvement.

SP10 "The unsaid": development of an editorial project of narrative medicine in a breast unit

Authors: V.Camilleri, M.Ghilli, F.Niccolai, G. Amunni, A. Falchi, F. Felici, M. Roncella
Breast Unit of Azienda Ospedaliero Universitaria Pisana
Istituto Toscano Tumori- ITT
Scuola Superiore Sant'Anna-Laboratorio MES-Pisa

Abstract

Rationale: The Narrative Medicine comes with trying to fill an "empty space" left by the evidence-based medicine approach that avoids of taking into account personal aspects of the patient. The ITT undertook a project in our Breast unit, exclusively involved in breast cancer, that represent a context where there is a particular need for integration between the professionals.
Research Hypothesis: The purpose is to sensitize patients to what is the diagnostic-therapeutic procedure full of stress and uncertainty, and to support professionals, imprisoned in the rhythms of care, often standardized and depersonalized, improving communication skills, and ability to grasp the patient's unexpressed needs. This could lead to an optimal decision making process, through a more active and aware patient's participation and an increased physician's ability to adapt therapeutic choices to the real patient's needs.
Methods: We have organised a series of training sessions, coordinated by a writer and the psychotherapist dedicated to psycho-oncologic support, for seven patients, with the supervision of the centre director. In six months there have been periodic group meetings aimed at sharing and processing of individual experiences, at the same time, through a creative writing course, professionals and patients have been encouraged to tell their own experiences in a narrative form.
The end product was a small book that will be implemented throughout the inside of the structure and at all points of the breast network host in Tuscany, and in bookstores.
Discussion: This project could improve the quality standards of the Regional Health Service expanding and comparing the spectrum of experience of the various players, declined in the different stages of treatment; it could moreover provide support to patients, family members and professionals, and finally disclose to a wider audience of citizens a greater awareness of the care pathway and in general the experience of illness.

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SP14 Partnering with patients for best outcomes

Author: D.Cohen, M.Szekendi
Datix Ltd. (UK) and Datix (USA), Inc.

Abstract

Rationale: Clear communication is essential to partnering with patients. Inadequacies in communication may lead to unrealistic expectations, less than optimal outcomes, harm and litigation. Challenges in communication reside in three domains: the content of information to be shared, the manner in which information is shared, and the ability of patients to comprehend information. Healthcare information can be very complicated, not all healthcare professionals are good communicators, the language we use may be not understood by patients and may also be alarming or frightening. Each patient's ability to comprehend information can be colored by intellectual capabilities, personality traits, fears, emotions, past experiences, language fluency, and belief systems.

Research questions/hypotheses: Case studies that portray communication challenges are presented with particular focus on:

1. Striving for a Culture of Candor – Disclosure and Transparency
2. Explaining illnesses/results of investigations
3. Care planning – why belief systems matter when partnering
4. Informed consent – what patient's really hear and understand
5. Informed consent – when conflicts of interest abound
6. Failing despite best efforts – future strategies
7. Planning for end of life care

Methods: Case studies portraying examples of communication successes and failures will be presented. Where appropriate, elements of the recently described Relationship: Establishment, Development and Engagement (REDE) model* for enhancing communication will be highlighted.

*Windover A. et al. The REDE model of healthcare communication: Optimizing relationship as a therapeutic agent. Journal of Patient Experience 2014;1:8-13

Results: This is not a study with discrete data elements, but rather a session to stimulate dialogue. A compendium of commentaries related to communication will be distributed.

Discussion/implications/conclusions: A foundation of medical ethics is the autonomy of patients to make decisions, and decision-making requires a frank, compassionate exchange of information between professionals and patients. Only by keeping the best outcomes in mind can clinicians and patients engage collaboratively for success.

SP57 A 10-year journey of engaging patients in patient safety education, research, and improvement

Authors: K.Smith, M.Hatlie, D.B.Mayer, T.B.McDonald
MedStar Health Research Institute, USA

Abstract

Rationale: Engaging patients and patient advocates is an evolving concept based in medical ethics and human rights that historically has not included involvement in patient safety or clinical improvement. Approaches on why and how to best engage patients remains unclear.

Research Question: To describe the experience of engaging patients and families in patient safety and communication and resolution program (CRP) education, research, and clinical service.

Methods: A historical prospective approach to examining patient engagement in CRP education, research, and improvement initiatives was employed. Thematic review explored the activities patients engaged in, infrastructure required, characteristics of participants and stakeholders, and the effectiveness of those efforts.

Results: Patient engagement in CRP activities increased between 2004 and 2014. Engagement was influenced by implementation barriers and reframing the roles of patients and patient advocates in outcomes improvement. Engagement was first achieved in education. Patients served as stakeholders on curriculum committees, guest faculty, and advisors for CRP development. In 2009, patients began to actively engage in research as national advisors and collaborators on two funded studies, resulting in more than 30 presentations, 15 abstracts, numerous blog and social media posts, and 3 patient-led manuscripts. Engagement continued to evolve, with patient and family members included on medical staff peer review and patient safety committees, ensuring accountability for learning from medical error and patient harm. Here, engagement resulted in enhanced respect, committee attendance, and improved CRP components.

Conclusion: Our 10-years of experience engaging patients demonstrates several common characteristics for success. First, strong leadership and commitment to improvement are requisite for active engagement. Second, institutional courage is required to share openly our mistakes and measures to fix them. Third, infrastructure is important to hardwire patient engagement in continuous improvement. Fourth, patient engagement in healthcare is critical for improvement and yields significant and immeasurable results.

ISCOME 2015 SPEEDY PRESENTATIONS

SP6 An audit patient partecipation: a Valdisieve Hospital experience

Authors: F.Bini, S.Fenigli, A.Lumachi, C.Magnani, AR.Salaris, C.Tronconi, V.Vizzaidi, A. Molisso, L. Ombroni
CRG Valdisieve Hospital, Italy

Abstract

Rationale: The Clinical Risk Group of Valdisieve Hospital born in 2013; it' made by a Clinical Risk Manager and 7 Facilitators representing each branch of the structure.
It has been created an incident reporting system to gather professionals' and users' reports above the risks or the problems of the service.
Some of those reports are approached by a Clinical Audit, a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.
Answers: We try to understand the reasons for a wrong patient's blood test outcome.
Methods: Clinical Audit with the involved patient.
Results: Thanks to the Clinical Audit, we could identify a fault in the process and modify it.
The patient took an important part, feeling happy to be an active member in the Clinical Governance.
Conclusions: Clinical Governance is a systematic approach to maintaining and improving the quality of patient care that need the patients experiences to improve the system. This is a way to promote and improve the link between patients and health carers, to ensure a higher patient's safety.
This Valdisieve Hospital experience is a lesson how to reach it, and, according to Berwick strategy, an attempt to bridge the gap between patients and carers, seeking to design quality into service delivery.

SP66 The regional counselling centre experience in the communication between citizens and health professionals

Author: L. Mazzei
Tuscany Region, Italy

Abstract

Rationale: Good communication between patients and health care professionals is crucial in building a relationship which will produce positive outcomes. Through communication it is possible to enhance the patients' awareness and resources so they can cope with possible issues during the course of treatment.
Research questions/hypotheses: Having accumulated over the years much experience in the field, the "Centro di Ascolto della Regione Toscana" (CARe) understands how the implementation of efficient communication is important for the effective approach to those issues related to clinical pathways and how this is beneficial for patients and for the efficiency of the whole system.
Methods: The CARe is staffed by Psychologists who offer telephonic counselling (at the toll-free number 800880101 for those who call within Italy) to patients with cancer, or rare diseases, and their families. The user is taken care of in full by the service, which, after an apt examination case-by-case, identifies both needs and problems pertaining to the case. At every point along the way, it restructures and redefines the "communication process" in collaboration with the Heath Care System, giving both counselling and psychological support.
Results: From the 6,087 cases surveyed by CARe, it is clear that communication difficulties arise every time patients' start a new phase of their clinical pathway (such as diagnosis, the planning of new cures, the follow up process, etc.) , and in the interaction between their local area and the hospital structure (discharges, home care, transportation etc.). CARe has addressed such issues redefining the patients' objectives, empowering them so they can cope with the problems associated with treatment.
Discussion/implications/conclusion: The CARe experience shows the important role that correct communication plays in every step of the way to a positive heath care outcome. It ameliorates the patient and health care professional relationship and it enhances self-efficacy therefore compliance whilst improving emotion regulation.

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TUESDAY, JUNE 16th

Speedy Presentations "Handover; Communication Skills; Education"

Chair: Giulio Toccafondi

SP61 Improving handover practices for general internal medicine in-patients: a randomized control trial

Authors: P.Tam, A.Shingina, A.Nijjar, M.Fok, R. Raghavan, C.Little, J.Bittman, N.Khan
University of British Columbia, Canada

Abstract

Rationale: The recent implementation of resident physician work hour restrictions in the United States and Canada has led to increased number of patient handovers, increased morbidity, and lower resident satisfaction. A number of strategies have been suggested to improve handover. However, no randomized controlled trials have been conducted to determine patient outcomes or resident satisfaction.

Research Question: What is the effect of a structured physician-to-physician handover process on proportion of patients handed over, patient outcomes, health resource utilization and physician satisfaction on an in-patient Internal Medicine service.

Methods: A randomized controlled study design was conducted over an 8 month period where medical teams were randomized to an intervention consisting of (a) 45 minute literature-based education session on handover; (b) a previously described "SIGNOUT" mnemonic for structured handover; (c) an original "iHAND" mnemonic to identify patients that need to be handed over; (d) a specific time and place reserved for face-to face handover. The control group was usual handover. Proportion of patients handed over was determined prospectively by charts. Patient outcomes and health resource utilization were determined from chart review. Resident satisfaction was assessed using voluntary anonymous surveys.

Results: A total of 473 patient days/encounters were included. The proportion of patients handed over was significantly higher in the intervention group (63 per 1000person/days) vs. control group (47 per 1000person/days) (p=0.002). Patient outcomes and average length of stay were not significantly different, however patients in the intervention group had higher resource utilization (p=0.01). Physician satisfaction with the handover process did not differ significantly between the two groups.

Conclusion: Despite an increased proportion of patients handed over, there was no significant difference with a structured handover strategy on patient outcomes, physician satisfaction, and health resources utilization. Other strategies for patient hand over need to be investigated.

SP42 Valdisieve hospital experience in handover

Authors: E. Borchi, S. Pinna,T. Benedetti, G. Sechi, S. Ricci, C. Oddo
Handover Team Valdisieve Hospital, Italy

Abstract

Like affirmed by several authors (Haggerty 2003, Wong 2008) handover in not only a transfer of information but essentially a transfer of responsability in the patient care processes.

Cross-unit handovers transfer responsibility for the patient among healthcare teams in different clinical units, with missed information,potentially placing patients at risk for adverse events.

Methods: In Valdisieve Hospital an interdisciplinary team , formed by doctors, nurses and OSS by medical and surgical ward, in november 2014, inspiring to SBAR (Thomas 2009), build an handover tool said IDACI: Identification, Diagnosis, Conditions, Assessment, Interventional complications.

Authors have controlled the use of IDACI monitoring the number of phone calls to medical on call.

Results: A preliminary report of three months of use of this tool shows that there a less lacking of information in handover because there is reduction of turn to medical on call

Conclusions: This preliminary report allows to say that this tool is useful in reduction of lacking of infomation in patient handover with an improvement of safety.

Moreover we note that with IDACI handover is a structured activity in daily patient care process.

Naturally the monitoring is continuing also for an eventually correction of IDACI.

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SP55 Implementation of the handover procedure in the paediatric Meyer hospital: results of the internal quality survey

Authors: A.Savelli[1], C.Neri[1], C.Lamanna[1], M.Baroni[1], S. Gianassi, G.Toccafondi[2]
[1] Meyer Children Hospital, Italy
[2] Clinical Risk Management and Patient Safety- Tuscany Region, Italy

Abstract

Rationale: Patients' handover is critical in complex health care. The lack of effective communication is the root cause for many the of sentinel events in the US and in Europe. Patient Safety hazards due to failures of communication, including miscommunication and omission of relevant information have been thoughtfully investigated. Cross-unit handover from one level of care to another poses additional risk to patient safety related to a transition from one organizational context to another. Professionals from different settings may have different perceptions about what is important to be conveyed. In 2012, cross unit transfers at Meyer Children Hospital varied, depending on the type of care unit, from 2% to 6% of admitted patient (9.384) . The Clinical Risk Management Unit in collaboration with the regional patient Safety Centre activated a research collaborative for implementing an hospital wide procedure for cross unit handover.

Research questions/hypotheses: Prior pilot studies identified the participation to a shared common ground as an enabling factor for safe handover. The implemented procedure is based on a clear responsibility definition at care transition and introduced the role of a transition nurse, in charge for the meaningful matching between the information of the sender and of the receiving unit on the basis of a shared minimum set of relevant information.

Methods: The minimum set of information is identified in inter-professional cross unit work group and is composed of a core standard information complemented with information tailored to the specific care transition at stake. The minimum set is conveyed in written and verbal forms and structured in order to adapt to the context of use. Transition nurses and multi-professional handover groups were appointed and activated throughout 2013 and 2014. An internal staff survey aiming at monitoring satisfaction regarding the handover procedure was distributed to the hospital practitioners.

Results: Of the 32% recipients (151 respondents), 94% know about the handover procedure and 89% is aware that the procedure is actually implemented in the care unit. The 32% and 39% respectively declare to adhere to the procedure "always" and "frequently". The 3% and the 15% declare not to use the handover procedure or to do it rarely. The procedure is generally implemented but some critical issues due to responsibility definition restrain the full adoption in the ED and in operating theatres.

Discussion: The practitioners participation to the handover procedure, after 3 months of full implementation, is high. The role of the transition nurse and the methodology used for the design and the communication of the minimum set are positively considered. The survey collected critical issues regarding the persistent omission of relevant information from some care unit and elicited several request of further information tailoring. After the consolidation of a solid groundwork additional resources need to be placed on the capillary diffusion of the procedure. The quality survey will be used to assesses the potential improvements.

SP22 Interpersonal communication in health care: developing a graduate course

Author: K.Eichhorn
State University of New York, Oswego, USA

Abstract

The purpose of this poster is to describe a newly developed course to be delivered as part of a Master's degree program in Strategic Communication and also a graduate health communication certificate program to be offered at SUNY Oswego during fall 2015. The author intent is to share and exchange perspectives on the delivery of course content, execution of graduate level projects, and assessment to effectively prepare and empower communication strategist that are working in the health care industries.

The course, entitled Interpersonal Communication in Health Care will examine how communication may be used to empower participants in health care interactions, influence family members, support caregivers, and create meaningful relationships in order to make more informed health decisions and achieve better health outcomes.

This course will examine how effective and appropriate communication will build constructive patient and provider relationships and how this will contribute to one's optimum health. While each relationship has unique features, all relationships possess certain communicative patterns, opportunities, and challenges for patients and providers. This course will discuss topics in health literacy, social support, the role of family members and caregivers, cultural influences, social identity, and the role of social media in developing effective and appropriate relationships in the health care context.

A Sample of Course Objectives includes:

- To identify interpersonal relationships that exists in the health care setting.
- To understand how the patient-provider relationship is an effective context for health behavior change.
- To enhance health literacy by increasing the ability to communicate about important health topics.
- To examine patient's informational, emotional, and psychological needs and providers' response to those needs.
- To identify the role of communication in care giving.
- To examine the role social media technologies on interpersonal relationships in the health care setting.

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SP67 The Academy of citizen: the contribution of the expert-patient to safety of care

Authors: E.Beleffi, T.Bellandi, S.Albolino, R.Tartaglia
Centre for Patient Safety, Careggi Academic Hospital, Firenze, Italy

Abstract

Rationale: The centrality of the citizen and the patient in the care process and care is an essential precondition in a modern health system interested in effectiveness and efficiency of services offered in terms of quality and safety of care.

Extensive experience implemented at the international level and in some Italian experiences shows how solutions detected in partnership between individuals and patient associations can efficaciously improve the quality and safety of assistance.

Patients and citizens education is the basic premise to share a common ground to develop projects finalized to prevent adverse events and to increase the reliability of our health care system.

Research questions/hypotheses: Starting from these assumptions, the Centre started a collaboration with the World Alliance Patient for Patient Safety (WHO) activating a series of initiatives to realize the involvement of citizens in policy promotion and in the development of patient safety. In order to achieve a real participation of citizens in the health service policies and to facilitate the contact and the exchange with the medical-scientific world, the Centre decided to organize a specific course focused to train citizen and patient association representatives in patient safety and quality themes to let them become expert-citizen in the evaluation of health care systems: the 'Academy of Citizen'.

The goals of this training have been promoting the involvement of representatives of patients to patient safety activities and creating an alliance with citizens in order to define strategies in partnership for improving patient safety.

Methods: The 'Academy of Citizen' is a course organized by the Centre in collaboration with the Laboratory PartecipaSalute of the Research Institute Mario Negri of Milan and it is an education event tailored on patients' representatives needs and point of views, focused to allow the creation of special initiatives dedicated to citizens' involvement. The Academy trained representatives of 30 patient's associations for a total of 100 participants coming from differentiated pathologies and from different Italian regions. The course consists in one year course (two edition: 2008 and 2013) performing an education program on the topics of patient safety, the evaluation and improvement of healthcare assistance, the identification of shared solutions on main issue of patient safety, including the communication of adverse events. Each training day combined the presentation of knowledge from experts and opportunities for discussion and work in small groups to develop and to test learning.

Results: The 'Academy of Citizen' has become a permanent appointment through which contribute to the construction of a bridge between citizens and professionals to improve the quality and safety of care. The participants to the Academy constitutes group of patients' representatives formally recognized regularly involved in the basic activities for promoting patient safety (audits on significant events, patient safety walkaround, definition of policies on patient safety at Tuscany regional level). During the biennium 2010/2011 14 patients' representatives participated to patient safety walkaround in fourteen different hospitals, while in 2014/2015 other 15 patients have taken actively part of this kind of visits. The point of view of patients is always an added value to the visit. Furthermore a dedicated group of patients trained with Academy have contributed in the design of a pair of multimedia tools for the training of health operators (also participating as actors) and in the development of four cartoon intended to promote the education of citizens to safety of care.

Discussion/implications/conclusions: The promotion of specific trainings, designed on patient needs and based on the characteristic contribution patients can ensure, facilitates the involvement of representatives of patients to patient safety activities and supports the creation of an alliance with citizens in order to define strategies in partnership for improving patient safety.

The 'Academy of Citizen' course represented fundamental premise for the creation and formalization of a group of citizens that actively participates in patient safety activities of the Tuscany Region.

SP12 LapList: Task 0 CRM operating-room training framework. A proposal to improve patient safety

Authors: R.L. Castellani[1], F.Venneri[2]
[1] MD Emergency and Surgical Department, Pederzoli Hospital, Peschiera del Garda (VR), Italy
[2] ASL 10, Firenze, Italy

Abstract

Rationale: Globally, each year, about 234million operations performed with 1 million deaths and 7 million disabling complications worldwide. In case of adverse events in operating theatre, generally at least 2 of the team members are involved and mishaps in human factor/communication are a frequent cause.

Research question: If patient safety mainly depends on team-communication, how may I achieve and improve it?

Methods: International literature on teamwork behavior in the operating theatre has been analyzed and much evidence has been taken from other high risk industries and complex settings as aviation and nuclear power-plants organization and the cultural reluctance to adopt these behaviours in healthcare settings.

Results: It's known that Crew Resource Management (CRM) operating-room training improves safety culture and outcome, expecially in health care systems in which CRM is properly integrated into educational and management systems.

Discussion: In this way we propose the LapList, aTASK 0 CRM operating-room training Framework, cross-linked with the pre-operative phase of all mini-invasive operations.

A sort of baseline in education, clinic, simulation and training fields.

ISCOME 2015 SPEEDY PRESENTATIONS

SP25 Communication competencies in countries of Portuguese language: where they are moving for?

Authors: C.Franco, R.Franco, M.Severo, M.A. Ferreira
Capes, Brasil
CNPQ, Brasil

Abstract

Rationale: Effective communication is crucial to everyday medical practice. These competences move ahead from the doctor's skills, like clinical history, to building the relationship with the patient, facilitation, negotiation and partnership.
Research question: To analyze the competences on Communication, Interpersonal and
Leadership Skills (assumed as Communication) to be developed by undergraduate
Medicine students in Portuguese-speaking countries (Angola, Brazil and Portugal), according to their national references documents.
Methods: The thematic analysis was performed in each Portuguese-speaking countries using as comparison: CanMed Framework, ACGME, Tomorrow's Doctors and Australian Medical Council. These 4 documents were the references documents at this study. This documents guide the education in the countries that have the best faculties of Medicine as the rank of the Best Medical Schools in the world.
Results: After extract all competences of references documents we defined nine subdomains. Five subdomains are related to the clinical communication skills, one with leadership and three with interpersonal communication and teamwork. All documents examined (3 Portuguese speaking countries and 4 references) contain the leadership subdomain. The presence of subdomains associated with clinical communication skills ranged between 60% and 80% of all possible competences. Interpersonal communication subdomains had a frequency often 33.3% (Angolan document and tomorrow's doctor) to 100% (ACGME and CanMed). When analyzed together all domains of competencies, the CanMed showed 100% of subdomains; Portugal 88.9%; ACGME, Tomorrow's Doctor and
Brazil 77.8%; and Australian Medical Concil and Angola 66.7%.
Discussion/Conclusions: all documents analyzed showed similarities relating the competencies of communication that doctors should have. Documents in Portuguese language are very resembling to the reference documents. Therefore it is concluded that the documents that guide medical training in Portuguese speaking countries are in consonance with the major world reference documents related to these competences.

SP20 Communication skills in health organization: means for promoting care safety and prevent litigation

Authors: A.De Palma, V.Maselli
Policlinico S.Orsola – Malpighi, Italy

Abstract

The permeability extent of the organization concerning the "positive" safety culture can express the interest and ability of that organization towards the promotion of actions improving healthcare quality and safety. The appropriate functioning of the internal and external organizational communication is the foundation of an environment of confidence and participation that should be established within the organization and between it and the main stakeholders of the healthcare system.
The analysis of the empirical data of the healthcare litigations and the vast literature on errors in medicine, have highlighted how conflicting relational dynamics between health professionals and patients, on the one hand, and the factors correlated to technical-professional errors that contribute to adverse events, on the other hand, are often fostered by flaws in communication skills at different levels.
In particular, many authors affirm that the communication skills of the organization and its members can play a crucial role during each course of care in ensuring some goals not "marketable" for the healthcare service. They include: patient safety (protection of the good health), the conscious adherence to the care of the patient on the basis of a shared decision making (protection of the right to self-determination) and the timely and transparent communication of the incident.
The aim of the present work is to evaluate, through a retrospective analysis of information sources available in some healthcare organizations, if the impact (in terms of frequency and seriousness of the outcome) of adverse events characterized by ineffective communication, can guide the prioritization of intervention actions (on organizational communication and/or on communication skills of the operators) in specific clinical settings and/or diagnostic and therapeutic paths.

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SP56 Voluntary peer-to-peer assessment in healthcare: a successful demonstration focusing on catheter-associated urinary tract infections

Author: M.Sawyer, K.Weeks, K.D'Souza, R.Demski
Johns Hopkins Hosital, The Johns Hopkins Armstrong Institute for Patient Safety, USA

Abstract

Rationale: Despite enormous effort and resources, patients continue to experience preventable harm at alarming rates. The healthcare industry must learn from other highly reliable industries that have demonstrable improvements to hazard identification and mitigation. The nuclear industry has made such improvements through the World Association for Nuclear Operators (WANO) Peer-to-Peer Assessment Program. This program involves in-depth, objective evaluation of plant operations by a team of peers with extensive experience in identifying and mitigating hazards. Previous manuscripts described inherent implementation barriers that must be overcome and it is unknown if this type of program could be translated to the healthcare industry.

Research questions/hypotheses: Can the WANO peer-to-peer assessment program be successfully implemented across 5 hospitals in the United States?

Methods: Five US-based hospitals in a large health system were selected to implement a peer-to-peer assessment program focused on improving CAUTI rates, a specific technical problem which increases costs, morbidity and mortality. The goal was to complete an in-depth, objective evaluation at each hospital with an independent peer evaluation team. Additionally, we targeted each implementation barrier previously identified: culture of fear, lack of trained peer reviewers, need for validated evaluation tools, lack of infrastructure, insufficient time and funding.

Results: Fifty multidisciplinary, volunteer peer reviewers from the 5 hospitals carried out assessments over 3 months. Areas of improvement included: measure performance, transparency, accountability, communication across organizations, processes, training/education, supplies, and implementation of evidenced-based interventions. Best practices were also identified and shared broadly across all organizations.

Discussion/implications/conclusions: The WANO peer-to-peer assessment program is a viable model to identify and mitigate preventable harm in healthcare. This demonstration suggests that prior implementation barriers can be overcome. We must continue toward our goal of eliminating preventable harm in patients. The peer-to-peer assessment program may just be the path forward.

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MONDAY, JUNE 15th

P54 Improving and Monitoring Learning System

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The Arezzo Health Company Usl 8, as a part of programs organizational communication, has created a dashboard, called "Improving and Monitoring Learining System" on critical issues, aimed at enterprise government and risk management. The Dashboard contains the integrated information needed to make fast decisions on improvement actions to implement, to monitor the effectiveness of choices, with a Total Quality Management approach of risks and corporate Governance. The Dashboard, which will have to be made interoperable with the Mes's Performance System and the Regional Clinical Risk System, illustrates, for the previous four years, for each Unit , the data for: leaks outside the Tuscany, Attractions, Claims, Sentinel Events, defects in the medical record compilation, falls, hospital infections, adverse drug reactions, failures of medical devices. Apart from these, the Dashboard shows the data collected from the surveys on work-related stress, the non-compliance found by the Regional Accreditation Commission, the non-conformities found by the Quality Certification evaluation Team, data on complaints of citizens: often the result of inaccurate or rude communications. It also shows the data Mes and those of the National Program Outcomes Agenas (PNE). The key issue is the relationship between internal problems and "satisfation mirror", how business problems reflect on the external perception of the Health Company. By the Report, the Department Directors are required to develop an annual Improving Plan in which list the training courses to be included in the next Business Plan for Training; internal audits; procedures as they deem necessary to prevent critical situations that are repeated, or prevent catastrophic events that have occurred in their Operational Units, defining in agreement with the Management, organization actions they consider priority.

P1 Patient Satisfaction: A Comparison between Governmental and Private Out Patient Clinics in Taif, Saudi Arabia

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Abstract

Objective: This study aimed to identify and compare factors that contribute for patient satisfaction towards the medical care services at the outpatient clinic in governmental health clinics (Taif University Outpatient Clinics) that provide service for university staff and students and private clinics (AL-Ameen Hospital Outpatient Department) in Taif, Saudi Arabia.

Methods: Using random sampling design. A self-administered (Arabic/English) questionnaire was used to conduct the interviews. Participants were selected using convenience sampling for both the governmental and private clinics. The results were analyzed using Pearson's chi-square test and compared using analysis of variance (ANOVA) methods with the use of computer software (SPSS 20.)

Results: A total of 356 patients were participated, comprising 141 patients from the government clinics and 215 patients from private clinics. About 75% of the patients were Saudi (69% in Government Out Patient Department- GOPD and 79% in Private Out Patient Department- POPD); Male patients were (49.1%) with 42% in GOPC and 54% in POPD. Patient with university degree were the majority of the patients in GOPD with (56.03%) and with (51.16%) in POPD where HS education level was significantly higher in POPD (40.93%) in comparison to GOPC (29.79%). Generally, Opinion about level of care provided was significantly higher in POPD (77%) than GOPD with (59%), where the physician explain way of taking medication in the GOPD was (42%) compared to (55%) in the POPD. Waiting time >30Min was (7.09%) in GOPD while it was (30.70%) in POPD. Time spent during examination >30 Min was (3.55%) in GOPD while it was (7.91%) in POPD. Satisfaction about working hours was significantly less the in GOPD (29%) compared to (44%) in POPD. The recommendation was almost the same with (35%) for GOPD and POPD.

Conclusion: This study provides important information that could be used by providers to monitor and improved the quality of medical care in the respective sector. Although patients at the POPD were more satisfied than those at GOPD with the health care they received, eight of the predictors of patient satisfaction in this study were common to both settings.

Recommendations: OPD in both categories should work to improve the waiting time and time spent during examination.

P35 Medico-legal implications related to communication defects among clinicians and patients: complaints as an opportunity

Authors: B.Guidi, MD; M.Martelloni
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Abstract

Rationale: Why communication is important to improve quality in healthcare

Research questions/hypotheses: Communication is the foundation of partnerships between the patient, family, and clinicians and influence the safety and quality of care received during the hospital stay. For physicians an effective communication represents also a deontological obligation. Effective communication can improve patient outcomes, patient safety and perceptions of quality. Conversely communication defects have negative consequences, they conduct to a lack of confidence in the medical system and lead to a lawsuit.

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Methods: We describe a review of patient complaints. An analysis of this data reveals that complaints based on communication issues are consistently the most prevalent reason for complaints against physicians. The nature of the communication complaints against physicians varies markedly.
Results: In this presentation, we describe how patient complaint profiles have supported non-punitive alertness feedback and strategic interventions of risk management designed to improve safety and reduce lawsuit risk.
Discussion/implications/conclusions: We conclude that communication skills are vital for physicians to effectively provide patient care, and poor communication skills are tied to negative outcomes, patient concerns can be an important force for promoting safety.

P34 Trend of healthcare-associated infections and antimicrobial use in a large tertiary-care Italian hospital

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Abstract
Background: Biannual prevalence surveys, in May and November, of healthcare-associated infections (HAIs) between 2012 and 2014 were conducted in Careggi University Hospital, a large tertiary-care teaching hospital in Florence, Italy, with about 1,500-bed units and 55,637-patient discharges in 2013. During this period, actions to improve HAIs prevention were implemented, including strengthened isolation measures and contact precautions, adoption of care bundles for invasive procedures and hand hygiene; local guidelines about surgical prophylaxis were also introduced.
Research questions: To assess the impact of these measures on HAIs rates.
Methods: The average surveyed patients was 587; for each patient clinical, demographic and antibiotic therapy data were recorded in accordance with the "ECDC Point prevalence survey of HAI and antimicrobial use in European acute care hospitals (ECDC PPS) protocol" version 4.3. The date of onset, infection site and microbiological data were evaluated. Univariate analysis was used to analyze changes in HAIs rates over time.
Results: There was a statistically significant ($p < 0.001$) reduction in prevalence of HAIs (from 10% in May 2012 to 6% in November 2014); decrease was particularly evident in medical wards and intensive care units: from 8,6% to 4,5 and from 31,5% to 15,6 respectively ($p < 0,05$).
In all surveys S. aureus, E.coli and K. pneumoniae were the microorganisms most frequently isolates, with an increasing trend in K. pneumoniae resistant to carbapenems. Conversely, significant progressive reduction in C. difficile infections was observed. The rate of patients received antimicrobials drugs did not change significantly over time (from 50,4 % to 49,5%), but antibiotics most commonly used shift from third generation cephalosporins and quinolones to beta-lactam-beta-lactamase inhibitor combinations.
Conclusions: Multimodal approach to improve HAIs prevention and use of a bundled strategy was essential in decreasing infection rates. Repeated prevalence surveys are an effective tool to monitor HAIs and to increase awareness among the healthcare personnel.

P33 Project to reduce unnecessary urinary catheter use and to prevent catheter-associated urinary tract infections

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Abstract
Rationale: International studies reported that 12-25% of patients will have an urinary catheter placed during their hospitalization with half of them without an appropriate indication. Use of indwelling urinary catheters can lead to complications, most commonly catheter-associated urinary tract infections (CAUTI), with increase mortality, hospital costs, and length of stay.
Aims: A pre-post intervention study will be project in a tertiary-care hospital in Italy. We assessed urinary catheter's appropriateness and prevalence of CAUTI; we implemented interventions to avoid unnecessary urinary catheters and CAUTI. Results will be evaluated six months later.
Methods: Careggi University Hospital is a large tertiary-care teaching hospital in Florence, Italy, with about 1,500-bed units and 55,637-patient discharges in 2013. The prevalence survey was conducted on November 2014. For each patient clinical and demographical data, indications of catheter's use according to international guidelines and CAUTI were recorded.
Results: A total 637 patients were investigated, 228 of these had an indwelling urinary catheter. The mean age of patients with urinary catheter was significantly higher than patients without catheter (70,3 y and 61,1 y respectively, $p< 0,05$). The overall prevalence of urinary catheterization was 35,8% (highest prevalence in intensive care units). The most frequent indication for urinary catheter's insertion was immobilization for trauma or surgery (35,4%) and perioperative use in selected surgeries (31,5%). The unnecessary catheter's use rate was 21,9% (up to 51% in medical wards). Prevalence of CAUTI was 3% and microorganisms most commonly isolates were multi-drug resistant bacteria, such as extended-spectrum b-lactamase (ESBL)-producing Escherichia coli and Klebsiella pneumoniae carbapenemase (KPC)-producing.
Conclusions: To increase appropriate use of urinary catheter and prevent CAUTI, we created a multidisciplinary team composed by physicians and nurses. The team will improve education and primary prevention introducing specific bundles (insertion of catheters based on indications, maintenance of sterility and early catheter removal). We will check the results of these interventions in six months.

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P32 Risk Management to increase quality in ambulatory care of the national institute for insurance against accidents at work (INAIL)

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Abstract

Rationale: In the comprehensive and integrated system of workers protection, INAIL also provides outpatient care (4134806 in 2014) and diagnostic tests (354850 in 2014). The Institute is trying to improve the quality of health services and homogenize the behavior at the national level, adopting existing risk identification and analysis models. Research questions/hypotheses. The aim of this study is to identify the risk areas in ambulatory care hypothesizing and introducing improvement measures.

Methods: After mapping with FMECA methodology healthcare risks in ambulatory care settings, we delivered a questionnaire on risk perception in their activities to 1476 healthcare professionals (doctors, nurses, radiographers, physiotherapists, orthopedic technicians). For all the variables descriptive statistics were performed. Chi-square test with residual analysis was used to compare categorical variables between groups. Statistical analysis was carried out using IBM SPSS for Windows, version 21.0. Significance level was set to $p \leq 0.05$.

Results: 1115 healthcare professionals responded to questionnaire (rate of compliance 75.5%). Emergency management was the main risk area (78.1%). 55% of healthcare professionals has highlighted the occurrence of an adverse event or near miss in the last 5 years. The most reported event was the fall (162), followed by an error or delay in diagnosis (137) and by an error in identification of the patient (112). Lack of communication was identified as the major cause of failure.

Discussion/implications/Conclusions: The limits of a proactive approach is still debated. Certainly, a structured system of risk management with bottom up modalities will represent the gold standard in INAIL. Identified the main risk area, we've introduced a general procedure for managing critical events. We tried to solve the main problem detected and to give an effective tool to manage emergencies. With another questionnaire it will be tested if emergency management will still be perceived by healthcare professionals as high risk.

P65 Ergonomy in mini-invasive operating-room: safe performance saves lives!

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Abstract

Rationale: with the first lap-chole ever published all over the world by Philippe Mouret in 1987, Surgery has not been the same.

First time in the history of surgery, the surgical field is transmitted electronically to monitor, exploration, preparation and resection of the organs is mediated by specific instruments instead hands are out and the team around, and not on the patient's body.

In this way there is the dissociation of the reflex arc between the eye and the hand, and a different view concern the open technique.

In reality, in fact lap-Chole vision is from the bottom up, exactly the opposite of the open technique.

The number of monitors their disposal and that of the team in the operating room are essential to maximize the efficiency of performance.

Research questions/hypotheses: in this paper we analyze the risk of ergonomic nature, both physical and cognitive, the surgical team, the surgeon especially, related to the use of new technologies, in order to maximize performance efficiency, ensuring high standards and maximum safety for the operator and the patient.

Methods: we observed several teams of surgeons engaged in laparoscopic surgeons in the end we interviewed to understand their problems and how to solve them.

Results: respondents reported discomfort in your neck, shoulders and back, very few have identified as the cause of the hassles available to the team and monitors, most failed to identify the specific cause of physical discomfort.

Conclusion: The absence of ergonomic guidelines is a serious problem that poses a risk to the health of both operators and for the safety of patients.

P37 A program for prevention of Post Partum Depression

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Abstract

Background: Post Partum Depression (PPD) is a major public health problem; the prevalence is estimated to be 10 – 20%, (peak incidence between 4 – 12 weeks post partum). This disorder has a threefold impact on the health of the mother and on the psycho-somatic development of the child (increased risk for attachment difficulties, impaired motor development, emotional dysregulation). Despite the prevalence of PPD and the psychosocial consequences most cased are not identified (Nauert, 2014; Glasser, 2013).

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The goals of this program were to develop an intervention for identifying women at risk for PDD and to assess acceptability of the screening in UU.FF. Consultoriali (UU.FF. CONS) of ASL 3 Pistoia.
Method: At 20 hours training program was conducted for midwives, gynecologists, psychologists and endocrinologists which included theoretical aspects of affective disorders during pregnancy and post natal time, as well as review of all guidelines for the screening and intervention.
The program included all women (>18 years) attending the UU.FF. CONS of Montecatini and Pistoia approximately between two week and 12 months after delivery. Depressive symptoms risks were assessed using the PPDS (Post Partum Depression Screening Scale), a self-rating questionnaire (Giunti OS, 2010). At all women were offered an information of the opportunity by the midwives and asked to participate after delivery.
Results: This program began in March 2015. In the first months we have identified some women at risk discomfort. These women had already been evaluated by psychologists of UU.FF. CONS. A brochure was created to facilitate the knowledge of the service offered, but this intervention required an adequate ability of communications.

P51 Pressure sores related to the use of medical devices: the importance of communication

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Abstract
Rationale: The use of medical devices in the clinical care of the patient in intensive care plays a great role both in the diagnostic phase just like in the therapeutic. Such devices, however, if not used in proper manner, the risk of iatrogenic lesions produce minimal skin that if unnoticed are able to determine lesions of greater gravity.
Hypotheses: Determine the mode of assessment, prevention and treatment of injuries caused by the use of medical devices by the nursing staff and, on the basis of the results, identify methods of intervention.
Methods: A monitoring period highlighted the methods of assessment, prevention and treatment of injuries caused by the use of medical devices in four intensive care units, 3 for adults and one infant.
An initial period of observation, through the use of checklist, allowed to analyze the nursing practice in reference to the management of medical devices; then was administered to the same sample a questionnaire of knowledge about the proper management of medical devices in view of prevention of pressure sores.
Results: The analysis of data for the monitoring period and the questionnaire showed that the practice of care was not always monitored in line with good practice and scientific evidence, and as stated in the questionnaire reflected, in principle, correct concepts.
Emerged therefore the need to create unique tools and shared, but above all easy to read and consultation to highlight in an immediate action to ensure the proper care during practice.
Conclusions: This study has allowed the creation of two working groups who has developed information

P41 Improving communication about medication: factors involved in tailoring information to patients' needs and enhancing empowerment

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UMC Utrecht, Netherlands

Abstract
Rationale: As shown previously, 5.6% of unplanned hospital admissions relate to adverse drug events (ADE's). Tailoring information to patients' needs and empowering patients regarding their medication management has been demonstrated to enhance drug adherence and may reduce ADE's. Yet, studies show that type and amount of information and its delivery often fail to match with patients' needs and preferences. When educating physicians in how to meet patients' information needs, knowledge on factors involved is essential.
Research question: Which factors are involved in patients' needs for information and how do these relate to patient empowerment regarding medication management?
Methods: Participating patients visited outpatient clinics of Internal Medicine and related specialties in two academic hospitals in the Netherlands. In-depth semi-structured interviews were performed at their homes. Akin to the principles of grounded theory, interviews were coded and analyzed using constant comparative analysis, to identify factors and investigate their relations.
Results: Analysis of interviews with nineteen participants (10F:9M, median age 55 (28-88), median no. of medications 8 (5-27)) showed five important themes regarding information needs and empowerment: wanting to be in control, experiencing powerlessness, battling with a basic negative attitude to medication, desiring a trustful relationship with the physician, needing information to be tailored. These themes are illustrated by verbatim quotations.
Discussion and Conclusions: Tailoring provision of information to patients' needs appears to enhance patient empowerment regarding medication management. Knowledge and insights about important themes as described here are crucial when educating physicians and equipping them with appropriate knowledge and skills to inform their patients in effective ways, aiming to foster drug adherence and reducing ADE's.

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P40 Using human factors methods to improve EMR design for an effective communication

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Abstract

Electronic Medical Record (EMR) has much potential to enhance quality and safety of patient care, especially when it is designed to promote effective care coordination, communication and complete information sharing among providers.

Although EMR has been deployed rapidly, only a little is known about how providers use it for communication. Some providers developed trust in the system and utilized it as the main source of communication (in which modality became primarily visual), while others refused to use it as they perceived it to be inefficient and difficult to use.

To prevent communication breakdown from system misuse and disuse, it is extremely critical to understand how EMR is utilized and evaluate its usability. In particular, during EMR transition, when an organization needs to identify what providers perceive as functional requirements of the new EMR.

We applied human factors (HF) concepts to determine system requirements (for communication) and test the system usability to identify designs that could potentially contribute to communication breakdown and/or promote effective communication. We analyzed Pediatric ED workflow and discovered nine steps in which EMR was used as a primary source of communication. We performed usability testing of the new EMR system to map its functions with the nine requirements.

There were six design issues that could potentially provoke communication breakdown (e.g., lack of system feedback) in which we mitigated through redesigns. We recognized six decent designs that could facilitate effective communication among providers (e.g., patient movement track board). We also cognitively mapped the two systems and noticed two major design deviations, which we emphasized during training to increase awareness.

Proactively performing workflow analysis and fidelity usability testing, by an HF specialist, is beneficial for: 1) reducing patient safety risks from communication breakdown; 2) redesigning EMR to improve efficiency and usage thus maximizing its benefits; and 3) increasing situational awareness.

P59 Don't talk about me, don't talk at me; talk to me & with me

Author: B.Stafford
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Abstract

The raison d'être is what is necessary for clinicians to improve patient safety by improving communications; between colleagues and between the clinician and their patient?

We know from both quantitative and qualitative evidence that person to person communication is a serious worldwide underperforming aspect of health care. The associated iatrogenic harm often started with failed communications and ultimately resulting in significant long term trauma in addition to the millions of wasted health care dollars each year.

Is there a benefit to the clinician to change?

What are the material costs to change? We have data that identifies and quantifies the levels of inappropriate treatment in addition to the stand along issue of overdiagnosis. Improved bridges of communications, between clinicians, between clinicians and their patients, will add to a positive change that can address this major cause of iatrogenic harm thus addressing the issue of improving patient safety.

The improvement addressed the double issue of reducing the unintended harm to the patient and saving in the cost of health care. The right health care at the right time. The failure of not understanding the difference between talking at a patient and talking with a patient continues with sad and expensive consequences.

Evidence to be presented will use published academic results and new primary evidence of the patient's journey. A solution to the problems of communications between clinicians and patients starts by building bridges of communications. There are benefits to clinicians by improving their communication skills. The advantages are in reduced human harm while gaining significant cost savings for an outlay of less than US$1 per day per patient.

P63 Communication of adverse events: simulation as a training approach to improve behaviour

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Florence Healthcare Service, Italy

Abstract

Rationale: The communication of an adverse event to the patient and/or family is not always easy and lean and healthcare professionals are not well trained to deal with this delicate moment and are burdened by the difficulty in choosing the right words and locations to meet patients and/or relatives. The Clinical Risk Management staff of the Florence Healthcare Service outlined a training program in which simulation is used as the main training methodology along with frontline lessons which illustrate the theoretical basis of communication and its use in healthcare systems.

Research Hypothesis: May simulation achieve the goal of improving communicational behaviours among healthcare professionals when they speak to patients and/or families on delicate issues such as adverse events or malpractice ? Simulation of scenarios regarding communication styles and behaviours in the nasty

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and good performances may support doctors, nurses and other professionals in achieving better empowerment ands reduce litigation,claims and lawsuits.
Methods: We conducted 6 training editions regarding the topic of communication barriers in risk management and patient safety. These editions registered 180 participants among doctors (different areas and specialities), nurses, lay people, obstetrics, psychiatrists, psychologists and other professionals working the field of healthcare. Each course was 4 hour length. One full hour regarded the psychological aspects of communications and in another half hour some claims letters were read and then a brief discussion followed.
We began with 3 main scenarios regarding: informed consent ,misunderstandings in diagnosis and prognosis, and an ambulatory setting. Each of the authors first performed as an actor/actress either as a patient, a family member, a doctor or a nurse. This approach to the scene is known as role-playing. Each scenario was then discussed with participants and then repeated according to suggestions. At the end of the course some videoclips of other scenarios were discussed and the purpose was to acquire as much information and knowledge as possible to suggest improvement in behavioural aspects of communication by healthcare professionals.
Discussion/Implications/Conclusions: Simulation and role-playing resulted in our experience to be the most accepted method of training among healthcare professionals mainly regarding the aspects of communication mishaps and pitfalls. Many litigation issues are due to lacks and defaults in communication. Training must be continous and preferably following an "on-the-job" scheme.

P44 Strategic development of Romanian sectorial healthcare services: focus on patient-suppliers' communication

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Abstract
Recent statistics are demonstrating a dynamic increase of the healthcare importance concerning Romanians health subject, from almost 5% in 2010 to an overpass of 40% in 2014. This clearly certifies that the beneficiary population shifted their interest status from traditional "patient concept" to "healthcare-services consumer", people who is now much more interested to be transparently informed and to be an integer part of the decisions to which is related.
Our qualitative and quantitative research on the medical services quality in Romania, is concentrated on the communication issues between patients and medical personnel, using meta-analysis, in order to produce better results: the evaluation method consists of both the patient and the medical personnel satisfaction questionnaires analysis. The questions were deployed in 145 hospitals, private or public, from 460 totally functioning nowadays in Romania.
The considered medical services within our research are: permanent and daily hospitalization and specialized medical services offered in ambulatory. From the included hospitals in our study, over 90% of the public units are offering the all range of medical services. The private hospital units offering continuous hospitalization are major oriented toward niche or single profile services, daily hospitalization services and speciality medical services.
The questionnaires to the medical personnel and to the patients, on the main aspects of the services, are done by the studied health organizations, then are applied to CoNAS, the independent hospital services quality certification organization, today transformed into "Agentia Nationala de Management al Calitati in Sanatate".
For medical service is not sufficient to provide just the material and technical endowments, or renowned medical doctors serving the population of hospitals. It is of outmost importance to build up a functional liaison between infrastructures, human resources and beneficiaries of services, hereby stated as efficient "COMMUNICATION".

P3 Tools for improving communication in the maternal and neonatal pathway. Research project in the field of childbirth safety and Medically Assisted Procreation (MAP)

Authors: S.Albolino, G.Dagliana,
Clinical Risk Managment and Patient Safety Center of Tuscany Region, Italy

Abstract
Rationale: Communication between members of the same equipe is considered a crucial element for the proper functioning of a complex organization as the healthcare systems. The healthcare systems are made up of people with different skills, attitudes to teamwork, self-consciousness and roles but that have to work together for the safety of other human beings. Without a structured communication and a structured work organization, failures in the process are more likely to happen. At the same time, a structured, opened and clear communication between doctors and patients is an instrument to guarantee a proper involvement of the patient in his clinical paths and represents barrier to systems' failures.
Research questions/hypotheses: The introduction of specific tools for work organization and equip communication in the delivery room can improve staff performance and increase adherence to good practices. The introduction of specific tools for the communication between doctor and patient in the MAP can reduce the possibility of taking a wrong dose of medication during self-administration of the therapy at home.
Methods: A Safety Checklist for the delivery room has been designed following criteria of ergonomics and usability and on the base of the WHO one. It has been put on trial in 4 hospitals of the Tuscany Region and by the end of March 2015 other 6 hospitals are expected to start. For the MAP an "Alert tool for the doctor" and an "Alert tool for the patient" have been designed in order to remind the five most important steps to be followed for doctors during the communication sessions with the patient and for the patient at home. They will be put on trial in 3 Italian Hospitals by the end of 2015.

Results: For both tools, we expect an incremental use of them with a high general compliance at the end. Thanks to the observation sessions, we will be able also to verify if the check list is used as a support to communication and decision making process. Thanks to interviews to the doctors working in MAP we will be able to evaluate if the alert tools help to reduce the number of patients' requests of clarification during self-administration of medication.

P8 Managerial approach and IT system to improve the OR process

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TIISO (ACOI - AICO - AIIC - SIAARTI -SIC)

Abstract

Rationale: The operating theatre represents one of the most critical hospital units, both in patient safety and financial terms.
In the OR, many different professionals work alongside each other, each with their own job-specific competencies, contributing to the health needs of each citizen. This all takes place within an organizational management structure that is extremely complex.
Inevitably, the stages of the entire process become very difficult to analyze, and it is clear that systems need to be introduced that can provide objective information that is not operator dependent. The presence of many different specialist workers, each with specific job categories, requires tight control by the management team, with the instruments to hand that ensure absolute transparency not only of data gathering, but also of data interpretation.
Research Question: Patient safety is strong related to organizational process, James Harrignton states that we can't improve what we can't understand and that we can't know we can't understand.
To make safety and sustainable the OR process we need to find organizational in order to guarantee the patient safety.
Methods: The management team must be able to know with absolute transparency all the stages of the process that make up the complex path of each surgical patient. With this information, all necessary changes will be able to be made to the workflow, rendering the system more effective, i.e. ensuring a better service to citizens under a user clinical point of view (perception of quality) and efficient, i.e. a reduction in business costs.
Discussion: A managerial approach provided by the IT System delivered healthcare managers, anesthesiologists and surgeons with clearly presented, relevant and unequivocal information regarding OR process in terms of how, who, where and when works beside the patient. By this way the healthcare manager may define long strategy for the OR process to reduce and prevent clinical risk for the patient and improve efficiency and performance for the whole process.

P16 The therapeutic alliance with parents: added value for safety of hospitalized minors

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Abstract

Rationale: In Neuropsychiatric care the relationship with minor is almost always mediated by the parents. To facilitate the safety of the treatment it is important to establish a therapeutic relationship with the parents, guaranteeing reception, communication and empathic listening. Responsible collaboration on behalf of the parents represents an added value and contributes to the success of treatment.
Hypothesis: A therapeutic alliance with parents reduces the risk of errors of identification, administration of pharmaceuticals and execution of medical exams; it favors the conscious acquisition of 2informed consent"; makes the handover safer and more efficient and can facilitate communication during negative event.
With patients with complex psychopathological disorders an alliance with parents can at times prevent dangerous situations such as, aggressiveness, suicidal behavior and flight risks that can manifest during recovery by surveillance and collaboration in managing critical situations.
Methods: To promote therapeutic alliance in our Institute, our patients, are guaranteed:
Visits between the doctors or psychologist and the parents during hospitalization.
Weekly support group for parents conducted by healthcare workers.
Weebly programs with the appointments (visit, exams)expected for the patient.
Clear information regarding the responsibility of the parents during recovery (Charter of Services, group for parents)
Suggestions for parents on posters.
Training of healthcare workers and frequent updates about communication and relationships (seminary, M&M, Audit).
Results
• 10 placed recommended
• Charters of Services
• Increased satisfaction of parents about communication with sanitary workers.
Conclusion: Investing resources (space and communication time dedicated to the parents of hospitalize patients) to establish a therapeutic alliance with the parent can facilitate the flow of value in clinical practice that ensures timeless, continuity and safety of care, reducing even the most serious risks.

ISCOME 2015 POSTER PRESENTATIONS

P17 The protected hospital discharge in infantile neuropsychiatry for continuity and safety in treatment

Authors: A.Cosenza A., M.Mucci, G.Masi
IRCCS Stella Maris Foundation, Italy

Abstract

Rationale: The hospital discharge, especially for the minors admitted as emergency psychiatric patients, with frequent and high psychosocial risk factors, is a very delicate moment for the possible critical aspects in the passage of the patient to the territory, mainly if it is not planned, considering the patient's needs and the territorial resources (integrated multiprofessional therapeutical rehabilitative services: psychiatric, psychological, educational, pharmacological, school, family). A lack of integration between the hospital and the territory might cause a premature, unplanned or delayed discharge for such patients with negative consequences on the minors' health and family background.

Hypotheses: The work analyses the critical aspects at the discharge and suggests ameliorative actions aiming at improving the quality and the continuity of the treatment course. The protected discharge must be thoroughly planned and coordinated and needs communication between the two poles of the hospital and the territorial transfer.

Let's consider possible risk indicators of an improper discharge:

- Admission within 30 days from discharge
- Treatment at first aid station because of relapses
- Other interventions (police officers, social services ,juvenile court)

Methods: A working team is set up for each discharge(8 cases) with IPASS application and Handover sheet. For more complex cases the analysis makes use of CRM (RLS) methodology.

Results:

- Increased internal and external communication
- Drawing up of a specific Handover sheet
- Identifying of possible ways of assistance and protected discharge
- Meeting at Stella Maris Foundation and regional Units of Childhood Mental Health

Conclusions: To assure a continuity between hospital and territory through specific procedures of handing over and protected discharge is fundamental in infantile neuropsychiatry so that unfavorable evolutive processes can be avoided (chronicity, worsening, relapses). It is also necessary to optimize the resources in order to eliminate expensive forms of assistance and treatment.

P21 A pilot project monitoring use, application and implementation of surgical checklist in Abruzzo

Authors: M.C.Di Filippo[1], A.Muraglia[2], Q.Tozzi[3], L.Fabiani1
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[3] AGE.NA.S. Agenzia Nazionale Servizi Sanitari Regionali, Roma, Italy

Abstract

Rationale: The use of WHO Surgical Safety Checklist in all operative procedures improves patient safety and can reduce post-operative complications. The application of checklist is intended not only as formal act rather than an expression of teamwork of all the operating room members. AGE.NA.S, the Italian agency for regional sanitary services and Regione Abruzzo joined a monitoring project on application and implementation of surgical checklist in Abruzzo.

Research questions: Implementation of surgical checklist depends on many factors such as cultural, structural, organizational, economic and on socio-cultural patterns. In order to evaluate the application and implementation of checklist in Abruzzo a multiple step interventions were planned such as, monitor and supervise the application of checklist. The study also focused on limits and barriers to effective implementation of a surgical checklist and to develop a strategy for improve the use.

Methods: A technical committee was established to coordinate survey and visit operating room during project lifetime. In a preliminary evaluation, all surgical operative units of Abruzzo hospitals were invited on self administration of survey indicating the adherence rating. A second step consists in repeated safety walk around to randomly revise samples of medical records. The primary outcome is the adherence evaluated as presence/absence of filled checklist. The secondary outcome is the analysis of partially completed checklist. Critical point evidenced by walk around data were acknowledged and focused formative and collaborative activities were activated.

Results and discussion: Significant differences in terms of adherence to checklist were recorded before and post formative activities suggesting the beneficial effects of continuous educational program. Preliminary data obtained reveal a high compliance for the checklist application and audit/peer review of data are still in progress.

From the revision of uncompleted checklist and the detailed analysis of non compiled items critical suggestion are expected to develop future strategies for successful implementations.

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P27 "No interruption tabards" in general pediatrics at Meyer children's hospital

Authors: G.Frangioni
AOU Meyer, Florence, Italy

Abstract

Rationale: The lack of signal elements between operators and users can produce errors due to the interruptions during the therapeutic process.
Research questions; Aim was the testing of signaling tabards for operators respect to the prevention of interruptions, safety of the therapeutic process, perception and comfort.
Method: The survey was carried out through field observation by the method of shadowing, structured interviews, analysis of documentation and internal procedures. Research and development were conducted through an ergonomic approach in the physical, cognitive and organizational aspects of the process.
Results: Acceptance of the tabards among operators is not homogeneous but subjective.
Observations have detected a lack of training compared to interruption and signaling elements, assuming a poor knowledge and acceptance of their purpose and meaning. Ongoing explanations have increased the collaboration and acceptance by operators.
The tabards are positively integrated with mobile stations, carrying out a signaling function and safety for nurses. The introduction of the information sheet in patient rooms has increased the awareness of parents, found from reduced interruptions on nurses, while ensuring the patient care.
Conclusions: The introduction of new elements requests a proper communication to operators and users. The operators should be trained and informed to transmit meaning, purpose, potential problems, correct application and potential benefits. Training represents a moment of confrontation and collaboration for future improvement actions. Patients and parents should be informed with posters, leaflets or table tent that introduce and focus the attention in a simple, clear and repeated way (poster patient rooms). Ward admission is indicated as essential for a first users information, reducing incomprehension and future resistances.

P28 Non technical skills: a project to enhance the efficiency of communication with patients and teamwork

Authors: I.Fusco[1], S.Tempesti, G.Forgeschi[2], S.Borchi[2]
[1] USL 4, Prato, Italy
[2] Casa di Cura Villa Fiorita, Prato, Italy

Abstract

Rationale: communication problems within working groups are involved in 80% of adverse events, furthermore, many patients complain for poor communicative approach by Doctors and Nurses.
Research questions/hypotheses: improving communication skills, could help to reduce adverse events and promote better cooperation of the patient in the care process.
Methods: a multi-professional educational program on communication, organized in two days, was started in 2012. It involved 26 Physicians, 17 Nurses, 1 Biologist and 2 other Health Care Professional, working at Casa di Cura Villa Fiorita, a private hospital with 113 beds, in Prato, Tuscany. In the first day of the project, the health workers were provided, by a Psychologist – Psychoterapist, with the basic communication tools, then they were introduced to communication of adverse events. Trough simulations, conducted by a Physician, experienced in communication, they tested their communication skills with patients and within the working team. A second edition was held in 2014. The second phase of the project, started in 2013, involves 52 Nurses, 6 Physiotherapists and 33 Caregivers. It consists of specific meeting, 4 per year, with professional working in homogeneous settings, to address specific issues. At every meeting, the health workers are encouraged to tell their communication difficulties with patients and with colleagues. Then they are provided with the appropriate tools to manage the situation.
Conclusions: as reported from all project participants, learning to use communication tools correctly, helps health workers to better face the every day difficulties, to manage adverse events and, finally, to provide the patient the care he expects.

P30 Quality of life and satisfaction for the reconstructive surgery in patients with breast cancer

Authors: M. Ghilli, V. Camilleri, A. Murante, L. Colizzi, M. Roncella
Breast Unit of Azienda Ospedaliero Universitaria Pisana

Abstract

Rationale: In breast cancer surgery there is a general consensus on the deep impact of mastectomy and reconstruction on the body image and the self-sense. The breast q © (pusic al, et al., 2009) was developed to evaluate patient's perception of the before and after reconstructive surgery, examining quality of life (psychosocial well-being, physical, sexual well-being) and satisfaction (satisfaction with the breast, satisfaction with the outcomes and satisfaction with care). To date, few studies have evaluated the outcomes of the mastectomy with reconstruction taking into account the patient's perspective.
Research hypothesis: The purpose is to assess prospectively the quality of life and satisfaction of a sample of women with breast cancer, in relation to the outcomes of reconstructive surgery. We aim to recruit a larger sample compared to previous studies and to compare the subjective perception of surgical

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outcome by the patient with the evaluation of the aesthetic result by the surgeon, through a scale derived by aesthetic outcome indicators of seno-network (www.senonetwork.org).
Methods: Prospective administration of breast q©, in a sample of consecutive patients undergoing mastectomy with reconstruction, pre-operatively and post-operatively (after a month after reconstruction; after six months and after one year after surgery). We expect a large sample, since in our centre, in 2013, were surgically treated 665 patients with malignant disease, of which about one-third (230) received radical surgery, and about 200 received breast reconstruction.
Rusults: Results will be available available from the end of 2014.
Discussion: The optimization of surgical outcomes is one of the biggest challenges in breast cancer treatment. Despite over 60% of women survive for about 20 years after the initial presentation of the disease, about 40% reported dissatisfaction with the surgical decision making process. The evaluation of the data obtained through scales completed by the patient, the patient reported outcome measures could be an effective procedure for obtaining an improvement in the quality of care.

P31 Medication reconciliation in transition of care: role of communication between health care professionals

Authors: A.Giannelli, E.Volpi, M.Emdin, M.Baroni, S.Biagini, R.Gini, F.Lapi, M.Tanzini, T.Bellandi, G.Toccafondi
Fondazione Toscana Gabriele Monasterio, Italy

Abstract
Rationale: Poor communication and inadvertent information loss is the main cause of medication discrepancies between recommended treatment and actual outpatient medication use. As a consequence, medication errors represents one of the primary cause of discharge-related adverse drug events and patient readmission in hospital. Medication reconciliation (MedRec) objective is to ensure that accurate and comprehensive medication information is provided constantly to the patient across transitions of care. The cooperation between health care professionals has a remarkable role in preventing medication discrepancies.
Research questions/hypotheses: The MedRec study coordinated by the UO Farmaceutica Ospedaliera, Fondazione Toscana Gabriele Monasterio (FTGM), in collaboration with Regione Toscana, Gestione Rischio Clinico and Agenzia regionale di sanità della Toscana, is focused on analysis of different ways to record pre-admission medication list and identification of discrepancies at care transitions.
Methods: We identified patients admitted to Cardiothoracic Dept at FTGM between January and March 2013, taking at least four drugs. We reviewed methods used at admission to report therapy. Discrepancies between therapy at admission and physicians' admission medication orders were assessed with a two-step independent review by a pharmacist and a physician. We also compared the discharge prescriptions and the drugs reimbursed to patients by the Regional Healthcare Service throughout 9 months after discharge.
Results: 499 patients were enrolled in the study. Reporting methods at admission included self-report by the patient or caregiver, oral interview or family doctor list. According to the preliminary analysis, common discrepancies between the medications prescribed at discharge and those actually taken during the following 9 months were substitutions within the same therapeutic class (i.e. ATC betablockers C07, proton pump inhibitors A02, diuretics C03, ACE inhibitors C09).
Discussion: MedRec may become a requirement to assess the quality of the care transitions process in which health care professionals collaborate to improve patient safety. We observed a substitution of medications within the same ATC class in the post discharge period. This is probably due to different indications of the primary care sector. Nevertheless further research should be dedicated to this aspect. Preliminary results suggest that we need to improve the MedRec process at hospital admission and discharge, through a better collaboration between nurses, pharmacists and doctors, as well as a more structured coordination with family doctors to ensure safe and effective medication use.

P13 The clinical risk management is a fundamental component of the risk management

Authors: P.Catitti, F.Pettinelli, S.Bianchi, D.DiMambro
INAIL motor rehabilitation centre Volterra, Italy

Abstract
The safety of the patient in healthcare environment is gaining importance in every healthcare activity. Although many health realities use a standard clinical risk management, it is necessary to define the most accurate procedures for each specialistic area, along with a careful risk analysis and risk mapping.
The Inail Rehabilitation Center, located Inail in Volterra, mainly deals with injured workers with post traumatic musculoskeletals disorders. The center also perform activities to recover the working gestures that have been compromised (work hardening).This report proposes to explain the way to act, the procedures, the experience and the implementations of a rehabilitation ward through risk analysis, audit, mortality and morbidity review and alert reporting.
The main topics are: informed consent, patient identification, fall prevention, prevention of hospital infections, the environmental checklist, the prevention of mistakes in medication and physical therapy, deliveries between professionists, communication and management of electromedical equipment.

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P52 Communication and patient safety in complementary and integrative medicine

Authors: M.Di Stefano, E.Rossi
Ambulatorio di Omeopatia ASL 2 Lucca - Struttura regionale di riferimento per l'omeopatia, Italy

Abstract

One of the problems of communication about complementary, and/or integrative medicines is to face an opposite but similar attitude. On one hand, an uncritical attitude that tends to exaggerate the benefits and minimize the problems, which is typical of commercial websites. On the other hand an opposition, often connected with the area of academic medicine that plays an important role also in the media.

The difficulty in making good information, especially at popular level, it is often due to a partial knowledge of the topics, the permanence of prejudices and stereotypes, and the conflict of interest.

The media influences the use of health care interventions, and shapes perceptions of health and disease in far-reaching ways. Lay people often first learn about medical advances through the mainstream media, and health news can have a greater influence on public health-related expectations and behavior.

The number of websites offering information about complementary health approaches (often called CAM, complementary and alternative medicine) has increased greatly in the last years. Social networking websites have also become an important source of health information for a lot of people. However, this type of information is often decontextualized, referred imprecisely, and sometimes frankly false.

That's why an intervention of CM experts on these issues is crucial and requires a specific work based on three corner stones: accuracy, independence and a critical outlook.

This communication describes in details the tools of the Tuscany Network for Integrative Medicine in this area, and among them the Regional Journal MC Toscana. This publication and other tools such as websites, books and campaigns to the public allow clarifying the main aims of the integration of CM in the public health service of Tuscany.

The other initiatives conducted in the specific area of the safety and clinical risk in complementary medicine are also described.

P45 Communication, Workloads and Safety in Healthcare Well-being of doctors and nurses, performance and consequences on patient safety

Authors: A. Cerri[1], R. Tartaglia[1], T. Bellandi[1], C. Mengozzi[1], S. Piccione [2], F. Renzetti [2], L. Parrini [2], E. Mastrominico [2], M. Papani[2]
[1] GRC - Clinical Risk Management and Patient Safety Center of Tuscany Region
[2] INAIL - Regional General Direction of Tuscany

Rationale

Numerous literature publications have proved professionals' workload issues to create an array of critical safety problems for medical professionals and the public community at large. These topics concern modern work organization in healthcare systems and are capable of heavy, sometimes harmful impact on patients' and professionals' safety and well-being.

Research questions/hypotheses

The ways of communicating (as a team, with colleagues, patients' families, the organization as a whole) and excessive paperwork have sensible effects on workload perception, teamwork, patient safety and Healthcare workers' wellbeing.

Methods

- Ethnographic qualitative methods (semi -structured interviews, ambient examinations, participant and direct observation, job shadowing)
- Objective quantitative measures and data reviews (work shifts, work tasks, personal details e.g. age, years of service and so on)
- Objective quantitative measures and data reviews

Healthcare workers' data will undergo a multivariate analysis with National Outcome Program and other Performance indicators, as well as Patient Safety Indicators, such as Adverse events, Claims and Complaints.

Results

6 general surgery units have been involved and a deep examination of work records has been initiated. Preliminary data have been collected on hours worked, shifts, specific injuries (minor and major), surgical operations carried out, etc, showing initial hypothesis confirmation.

In the next months (possibly before june) the chosen wards and operating rooms will be directly observed using tools for measuring clinicians' patterns of work and communication; alongside, subjective scales will be used to broaden the correlations (e.i. UWES and WAI scales).

Discussion/implications

Certain types of tasks and disturbances correlate with occupational stress and fatigue, leading to critical aspects of clinical workloads and staffing, poor organizational performance indicators and adverse events incurrence.

Additional suggestion

There is still need to investigate how staffing related factors and administrative requests may have significant consequences on professionals' wellbeing, and time dedicated to patient care.

ISCOME ROUNDTABLE DISCUSSION PANELS

MONDAY, JUNE 15th

Cross-Professional Communication and Patient Safety

Chairs: D.Roter and R.Street
Panelists: R.Juhasz, J.Øvretveit, A.Rizzo B.Spitzberg, A.Wu.

"Communication problems" are identified in research and practice as a primary contributor to medical error and adverse events. Cross-professional and cross-specialty communication rank among the most frequent causes of patient safety events, particularly surrounding handoffs, whistleblowing, and team conflict. Evidence-based research and knowledge in this area is limited and currently draws little on communication science theories and methods for understanding potential causes and solutions.
The purpose of this roundtable discussion panel is to contribute insights and potential solutions from different disciplinary perspectives. The panelists will discuss tools and evidence from disciplines outside of healthcare that can advance the current knowledge, reflecting upon techniques and strategies how to effectively implement some of these strategies into everyday practice. Furthermore, the panelists will consider innovative transdisciplinary research directions and interventions to improve cross-specialty and cross-professional communication in practice, with the ultimate goal to reduce and manage the occurrence of risks, medical error, and adverse events.

TUESDAY, JUNE 16th

Provider-Patient Communication and Patient Safety

Chairs: J.Øvretveit and B. Spitzberg
Panelists: W.Afifi, W.Beach, J.Pham D.Roter, R.Street, , E.Vegni

Misunderstandings between patients and clinicians are embedded in unsuccessful interpersonal communication, resulting from the use of jargon, incomplete or ambiguous interaction, and other forms of miscommunication. Unfortunately, this problem is quite common and frequently contributes to poor quality and unsafe patient care. Much has been said and written about activating patients, but interpersonal communication is seldom considered as part of such empowerment strategies. Improving care to make it more patient-centered and to reduce risks requires more attention to patient-provider communication.
The goals of this panel are (a) to explore the main forms and causes of safety-compromising patient-provider interactions, and (b) to consider some proven and innovative interventions, including patient-provider health literacy, safety, and "speak out" campaigns. The panelists will discuss how communication science might contribute to the existing literature on this topic area, focusing in particular on safe diagnosis, safe adherence, and safe disclosure. In conclusion, the panelists will consider some ideas and priorities for future transdisciplinary research and innovations.

Reflections on the Past, Present and Future of Patient Safety

Chair: B.Stafford
Panelists: J.Bacou, S.Bovenga, N.Dhingra, G.Gensini, B.Kutryba, F.Vimercati

ISCOME 2015 LOCATION

CONGRESS VENUE
TERME TETTUCCIO
TERME TAMERICI
Viale Verdi 71
51016 Montecatini Terme

CONGRESS CHECK-IN AND REGISTRATION
The Registration desk will be open at the following times:
Sunday, June 14: 2:00 pm to 5:00 pm
Monday, June 15: 7:45 am to 5:00 pm
Tuesday, June 16: 8:00 am to 12:00 am

COLOURS ON BADGES ARE
DELEGATES: WHITE
SPEAKERS: BLUE
ACCOMPANYING PERSONS: GREEN

OFFICIAL LANGUAGE
The official language of the Congress is English. Simultaneous translation English/Italian and vice versa is provided in the plenary room.

BADGE AND CONFERENCE BAG
Registered participants can collect all conference documents at the registration desk of Terme Tettuccio. Congress badges are required for access to the scientific sessions, poster exhibition and social events. All registered delegates are required to wear their badge visibly throughout the conference.

CME ACCREDITATION
The ISCOME Conference has been accredited to the Italian Ministry of Health for **11,3 CME Credits**

PARTICIPANTS
To obtain credits, registered participants are required to:
• Wear the identification badge during working sessions
• Provide their signature and write entrance/exit times before and after attending the Conference
• Complete assessment and satisfaction questionnaires for each day

SPEAKERS
Speakers will be given 1 credit for each half-hour of consecutive teaching.
Speakers, moderators and discussants can decide to obtain credits as participants (see Participants).

ATTENDANCE TRACKING
Attendance will be tracked through participants' signature at the start/end of each day, and through assessment and satisfaction questionnaires.
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Credits will be given only if a participant attends 100% of the working sessions and provides correct answers to at least 75% of the questions included in the final assessment questionnaire. The Provider will send CME certificates to the participants after the Conference.

COFFEE BREAK AND LUNCH
Will take place at the Liberty Cafè Tettuccio and Grand Plaza

CONGRESS INFORMATION
All Speakers and Chairs should meet at least 10 minutes before their session begins to fix microphones

ORAL PRESENTATIONS/ TOP PAPER PANELS
Each presentation should be of 8/10 minutes duration

SPEEDY PRESENTATIONS
Each presentation should be 5 minutes duration

NO SMOKING POLICY
Smoking is not permitted anywhere in the conference area

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No cloakroom facilities are available on site. Any property found should be taken to the conference registration area, and lost property can be claimed there

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Limited medical staff is available on-site. Please contact the conference secretariat for details

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from Monday to Friday at 8.10-15.30

SHOPPING
Shops are open 9.30.-13.00 and 16.00-20.00 every day

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We recommend that you take out insurance to cover medical and travel expenses.
The congress fee does not include insurance

TRAVELLING:
PISA AIRPORT: 50 km from Montecatini Terme.
Most flights are in connection with other intercontinental and European flights. A train connects Pisa Airport to Lucca, and from Lucca to Montecatini Centro Station.
FLORENCE AIRPORT: 40 km from Montecatini Terme.
A shuttle service connects Florence airport to Florence railways station. A 30 minutes direct train connects Florence "S.M. Novella station" to Montecatini Centro station.
TRAIN SERVICES: Every 30 minutes a direct train connects Florence with Montecatini Terme. It takes about one hour from Florence. The nearest railway station is "MONTECATINI CENTRO". Every 30 minutes a train service connects Montecatini Centro to Lucca and from Lucca to Pisa Airport (no direct train).
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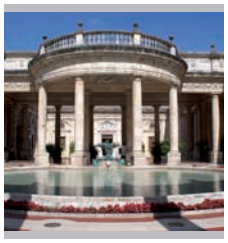
THE TOWN OF MONTECATINI TERME

It was founded and developed around its most precious riches, its waters. One of its most striking characteristics is the large green area in the "heart" of the city.
The spa park covers a surface of at least 460,000 sq./mt.
The town developed between 1800 and 1900. Formerly, it was called Bagni di Montecatini and only in 1928 took on its actual name, Montecatini Terme.
While the spa center called Tettuccio represents the thermal center of the city, Piazza del Popolo and its adjacent streets lined with their elegant shops, which form the city's commercial center, can be considered as the "living room" of Montecatini.
The square was the result of the enlargement of the old road "via Regia lucchese", which, as the name indicates, was the road connecting Lucca to Pistoia. It is here that the people from Montecatini choose to build their basilica. This was built in 1833 and designed by the architect Luigi Cambray Digny. However, as it turned out to be too small to serve the needs of the citizens, in 1962 it was decided that it should be torn down and rebuilt it according to the design of the architects Fagnoni, Spadolini, Stocchetti e Negri. In the center of the square is a fountain from 1913 which replaces an ancient loggia used for markets and trade fairs.
Viale Verdi, which leads to Tettuccio Spa, starts from the north side of the square. This avenue was designed in 1778 by the engineer Francesco Bambicci and originally was called Stradone dei Bagni.
It seems that it was the Grand Duke himself who wanted this street to resemble the broad avenues that at the time were being built around Europe.
Later, some of the main buildings of the city were built on this avenue, including Palazzo Comunale (the town hall) which was built on the former stables of the Grand Duke. This palace was embellished by decorations by Galileo Chini who designed some of the big skylights, painted the lunettes and decorated the vaults.
Just before the town hall, on the other side of the avenue is the Palazzina Regia, which originally was the summer residence of the Grand Duke Pietro Leopoldo and which today is the general headquarters of the Montecatini spas.
Montecatini Terme is considered one of Tuscany's capitals of Liberty Style. This is mainly because the Art Nouveau movement, which developed from the end of 1800 to the 1930s, coincided with a period of great development of the spa city.
Consequently, many public and private buildings were built in this style. Many of the examples of Liberty Style were left by one of the main artists of this period, Galileo Chini.
At the beginning of the avenue, starting from Piazza del Popolo, on the right is the building of Locanda Maggiore and the arcades of the Gambrinus, designed by the architect Bernardini in 1913.
All the spas present examples of Liberty Style. The decorations and the frescoes inside Tettuccio, whose authors are Basilio Cascella, Ezio Giovannozzi, Giuseppe Moroni, Giulio Bargellini and Maria Biseo, are of great artistic interest.
The beneficial properties of the Montecatini waters, which have been appreciated since ancient times, were officially recognized in 1417 in a treatise "De Balneorum Italiae proprietatibus" by Ugolino da Montecatini, professor at the universities of Pisa, Florence and Perugia and later justly regarded as the founder of "Italian Hydrology".
However, the real boom of interest for the curative proprieties of the mineral waters of our city took place at the time of the Grand Duke Leopoldo I, who commissioned the spas to be accurately studied, improved on the springs and above all started to reclaim the marsh area. The spa centers began to be built from 1733 onwards.
The thermal waters come from a fault that is 60-80 mt. deep.
During their journey to reach the surface, the waters collect minerals. When they come to the surface, from a bacteriological point of view they are pure and can be drunk without being treated. They are distinguished according to their characteristics into Strong, Medium and Light.
The therapeutic applications of the waters are very diverse, but medical control is nonetheless necessary. The main therapy consists of drinking the water and is thus referred to as "drink therapy."



TETTUCCIO SPA

Today, this spa center is the symbol of the city.
In the entrance hall, there is a painting portraying the spring by Giuseppe Moroni, while Galileo Chini decorated the ceiling of the central gallery.
Tettucio's water spurts from a large granite shell and is collected in a great vat in the square.
On the left is the drinking gallery with a long counter where water is served On the wall, the great master Basilio Cascella created seven large ceramic panels which represent the four phases of life: Childhood, Adolescence, Adulthood and Old Age. The other three represent Beauty, Spring and Strength.
The center has recently acquired a new hall, "Sala Portoghesi", created by the Roman architect Portoghesi.
Moreover, in 1998 a fountain featuring the metallic sculpture of the Japanese artist Susumo Shinguin was installed in the flower bed opposite the façade of Tettuccio.

EXCELSIOR SPA

It is the first spa center you come across when walking along Viale Verdi from the city center towards the spa area.
The building was first conceived as a casino and an elegant café.
Only after the First World War it was turned into a spa center.
The hall of waters done in Liberty Style and the swans' fountain are noteworthy.

TAMERICI SPA

The center was named after the tamarisk trees growing around its spring, which was discovered in 1843.
Its external appearance is reminiscent of a medieval castle displaying different architectural styles, including Tuscan Renaissance, Florentine Moorish and Liberty Style.
The decorations created by Galileo Chini around the center are delightful.
The circular Padiglione, which comes from Gabriele D'Annunzio's Villa "La Capponcina" in Florence, is also very interesting.
Tamerici is not a spa center, but rather the site of exhibitions, concerts and conferences.

SALUTE SPA

The spring was discovered by Benedetto Gabrielli in 1860 and bore his name for several years.
The rustic character of the present arrangement was achieved during the renovation which took place between 1922 and 1929. Inside the center is a large park

TORRETTA SPA

There are three springs in this center: Torretta, Giulia and Rinfresco.
It takes its name from the small tower built at the beginning of 1900 which dominates the center. The interior of the spa has a lovely park with centuries-old trees and small lakes. The center hosts concerts and art events.

LEOPOLDINE SPA

As the name of this spa center clearly indicates, it was built in honor of the Grand Duke Pietro Leopoldo.
The building dates back to 1775, but was completely renovated in 1926 when several charming halls were added to it. The thermal water "Leopoldina" comes directly from the spring into a fountain located in the internal garden.
GROCCO SPA
The establishment is located in the spa park across from the Tamerici Spa.
Currently there is a thermal pool used for motor rehabilitation

REGINA SPA

It is one of the oldest springs. Regina Spa is located inside Tettuccio park.
The center, built in travertine marble, consists of three areas: the water bar, lounge and treatment areas.
Opposite the main entrance of the center is the elegant Vasca dell'Airone - Heron Tub - created in 1925 by the sculptor Raffaele Romanelli.

REDI SPA

This center was built recently. It is dedicated to the great 17th century Tuscan doctor and scientist.
It features large halls for massage, mud therapy and there is the thermal pool.

Montecatini Alto

Really close to Montecatini Terme there is the town of Montecatini Alto. This sweet little Medieval town give you a beautiful panoramic view of Montecatini Terme and of all the Valdinievole area. It's an amazing place where to spend some hours during your trip in Tuscany.
You can reach Montecatini Alto by car (or also on foot) but the best way is using the "funicolare" an old fashioned cable car that transports you from Montecatini Terme up to the lovely town.

Hiking

There are scores of hiking trails throughout the hills surrounding Montecatini Terme. One popular trek is the trip from lower Montecatini Terme to upper Montecatini Alto. If you're feeling frisky you can skip the cable car and hot foot it up the roads. Going up takes a bit of work and a bit of time, but the path is mostly shaded by surrounding trees and the cut of the hill.

Biking

You can rent a bicycle and head out to the same paths in the hills that are good for hiking. If you want something more challenging you can rent a proper mountain bike and head to the trickier paths.

Jogging

The Parco delle Terme and the Parco delle Panteraie are both excellent for jogging, with the Parco delle Terme offering views of the spas in the area.

Golfing

Montecatini Golf Club with its 18 hole course par 72 measures 5857 mt . Set on an estate belonging to an old Tuscan family, this area offers superb panoramic views for the rich and various vegetation and for its historical and cultural aspects. The course is situated on a hilly area with holes of extraordinary technical and scenery attraction. The first nine holes are featured by olive trees that signs the gentle doglegs of the fairways and the border of the course, while the second nine are featured by the beautiful colors and perfume of the Mediterranean maquis made of heather, broom and laurel. Two lakes included on the course makes it more challenging.

Spelunking

Grotta Maona is one of Italy's famous caves and the only one with two pools that feed in from the hot springs. There are fantastic stalagmites and stalactites, and numerous rock formations. The path is well lit, but be sure to wear rubber soled shoes and perhaps bring some waterproof clothing.

Race Tracks

The Sesana Race Track of Montecatini Terme is excellent for a bit of fun and some gambling if it floats your boat.

FOR KIDS:

Termeland

You can get your children and spend some hours here making them play around. There are several and different games that can be used from children to every age.

Minigolf

Dipped in the green with Cafè and Restaurant , it is suitable for children of all ages.

Mykart

My Kart is the first indoor kart track with electric karts. The electric motor provides excellent recovery speed and in absolute silence. It is suitable for children and adults

Parco di Pinocchio

In Collodi, a small town not far from Montecatini Terme , you can visit the very original Pinocchio Park dedicated to the famous long-nosed marionette.
Pinocchio, the Talking Cricket, the Fairy with Turquoise Hair and all the others characters of "The Adventures of Pinocchio" were invented by the Florentine writer Carlo Lorenzini, known with the psedonym of Carlo Collodi (taken from the name of his mother's native village).
The park is set up completely outdoors. Walking inside the large garden, surrounded by the well-cared after vegetation, you'll find all the main protagonists of the story: Pinocchio, the Fairy with Turquoise Hair, the Cat and the Fox and many other characters from the novel virtually accompany visitors and remind them some of the most relevant passages of the book.

The Park of Pinocchio is an enchanted place, with an almost retro style atmosphere. So do not expect special effects or high technology attractions (at least not much more than several fountains with a few water games installed). Here, the offering is to stroll among several great bronze sculptures and others works by several artists that have been added to the garden ever since it first opening in 1956 up to today.

One of the most beautiful attractions of the Pinocchio park is without a doubt the great dogfish shark. You shouldn't miss entering the shark! After a quick zig-zag between its large and "sharp" teeth, you will be straight in the shark's belly. Then going up a few but narrow steps, you' ll come right up to the head of the animal, where you can enjoy a beautiful view all over the garden.

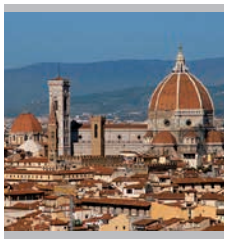
Dedicated to the youngest, you'll find some traditional carousels, didactic laboratories organized by the park's staff, a little puppet theater, a castle of ropes, giant chess board and other games around the garden.

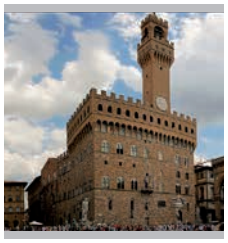
ISCOME 2015 CONFERENCE HOTELS

5 stars Hotels	Double room as single use (1 person)	Double room (2 people)
GRAND HOTEL & LA PACE 700 mt from the congress venue Luxury and elegant Liberty style Hotel	**€ 130.00**	**€ 190.00**
MONTECATINI PALACE HOTEL 650 mt from the congress venue. Modern and sophisticated Hotel with refined furnishings	**€ 100.00**	**€ 160.00**
4 stars Hotels		
GRAND HOTEL CROCE DI MALTA 600 mt from the congress venue. One of the most prestigious four stars “superior” hotels of the town	**€ 75.00**	**€ 115.00**
GRAND HOTEL TAMERICI & PRINCIPE 700 mt from the congress venue. Deluxe hotel of established tradition	**€ 75.00**	**€ 100.00**
HOTEL TETTUCCIO 400 mt from the congress venue. Historic charming Hotel	**€ 89.00**	**€ 99.00**
HOTEL MANZONI 400 mt. from the congress venue A lovely 4 stars SPA Hotel	**€ 68.00**	**€ 90.00**
3 stars Hotels		
HOTEL BELVEDERE 200 mt from the congress venue A very welcoming Hotel	**€ 65.00**	**€ 89.00**
HOTEL SAN MARCO 700 mt from the congress venue. Friendly, nice Hotel in quiet location	**€ 58.00**	**€ 70.00**
HOTEL ACCOMMODATION		
Rates include VAT, taxes, service and buffet breakfast		
Rates do not include CITY TAX 5 stars hotels: € 1.70 per person, per night 4 stars hotels: € 1.40 per person, per night 3 stars hotels: € 1.00 per person, per night		

ISCOME 2015 SOCIAL PROGRAM

SURROUNDINGS





FLORENCE

Florence's reputation as one of the most beautiful cities in the world is well deserved. Its rich artistic and architectural patrimony makes it into a true museum city.
The "heart" of the city is enclosed in the triangle formed by three squares: Piazza del Duomo, Piazza della Repubblica and Piazza della Signoria.
The Cathedral Square, Piazza del Duomo, is the religious center of the city as it features the immense cathedral Santa Maria del Fiore with its characteristic dome designed by Brunelleschi.
Its construction took almost 150 years: it started a few years before 1300 and was completed only in 1436.
The Battistero (Baptistery) of San Giovanni Battista, the patron saint of the city, is a few centuries older. Its gilded bronze portals depict episodes from the Old and New Testament, and are of great artistic value.
The square is dominated by Giotto's bell tower. Unfortunately, the great artist could only start his work, but was not able to see it finished.
It is 85 mt tall and in order to reach the top you have to climb 414 steps. Nevertheless, the view from the bell tower is truly unique.
Piazza della Repubblica is the old center of the city. Later, it was replaced by Piazza della Signoria which is dominated by Michelangelo's David and by the fountain featuring a marble statue of Neptune in the center, known as "Biancone".
Palazzo Vecchio, dominated by Arnolfo Tower was started in 1299 and modified at various times over the years.
The last and definitive renovation was the one led by Vasari around the first half of the 16th century.
The two halls, "Salone dei Cinquecento" and "Sala dei Dugento" feature paintings by Vasari, works by Michelangelo and a particular paneled ceiling by Giuliano and Benedetto da Maiano.
The Galleria degli Uffizi (Uffizi Gallery) is not far from the Loggia dei Lanzi, which has just been recently reopened to the public
The gallery is one of the most beautiful and well-known museums in the world. It contains works by Botticelli, Giotto, Piero della Francesca, Caravaggio, Raphael, Tiziano, Simone Martini, Duccio di Boninsegna, Cimabue, and also by Rembrandt, Rubens and Velasquez.
It has not been very long since it has been possible for tourists to enjoy the unique experience of going from the Gallery to Palazzo Pitti through the Corridoio Vasariano (Vasari's Corridor) over the Ponte Vecchio (Old Bridge).
From Palazzo Pitti, the seat of the Grand Dukes of Tuscany, you can also access the garden called Boboli, which covers 45,000 sq.mt. making it one of the largest in Italy. The building of the garden was commissioned by Eleonora da Toledo to Tribolo, who laid it out in 1550. Works of interest in the garden are a cave, "Grotta del Buontalenti", which displays decorations by Michelangelo, and the amphitheater.
Going from Ponte Vecchio towards the center, you come across the Fontana del Porcellino - the Boar's Fountain. This is a wild boar in bronze, sculpted by Pietro Tacca in 1612.
Santa Croce is considered one of the most important Gothic basilicas of Italy.
Next to the tombs of some great personalities of our country, including Michelangelo, Machiavelli, and Foscolo, the church also features paintings by Donatello and Rossellino, frescoes by Giotto and works by Nicola Pisano and Della Robbia
Santa Maria Novella is only two steps away from the station. Works by Masaccio, Ghirlandaio, Giambologna, young Michelangelo and Giotto are here as well.
Other churches containing valuable art works are Santissima Annunziata, Santo Spirito, Santa Trinita, San Miniato al Monte, Orsanmichele, San Firenze, and Ognissanti.
Florence is certainly a capital of art, but also of fashion, elegance and crafts, as attested by streets which are lined with prestigious shops that bear names from a remote past, such as via Calzaiuoli, Tornabuoni and Cerretani. However, for bargain hunters, there is also the market in San Lorenzo.
For those who want to enjoy a view of the city, the ideal spot is Michelangelo Square. It can be reached through Porta Romana, a tower dating back to 1326.

LUCCA & PISA

LUCCA

The first thing you will see arriving in Lucca are the town walls which are very well preserved and still today surround all the old town. Lucca is the only town in Italy entirely surrounded by walls.

The Town Walls

Since the Roman period the town has been surrounded by walls. In that period the walls had a quadrangular plan with four gates.
In the XII and XIII century new town walls were erected to include the new quarters of S. Maria Forisportam, S. Pietro Somaldi and S. Frediano.
These walls were 11 or 12 metres tall and were defended by towers. The gates of San Gervasio and Santa Maria dei Borghi belong to this period.
In the XVI century new works on the walls were started and at the end of the century the walls had the present shape with bastions.
In the first half of the XIX century the architect Lorenzo Nottolini began to transform the walls into the park you see today.
So if you visit Lucca you must have a nice walk along the walls.
If you walk or drive along the walls, you will see the gates, which are now six.
Porta San Pietro, Porta Santa Maria, Porta San Donato , Porta Elisa , Porta Sant'Anna and Porta San Jacopo
If you enter the town through Porta San Pietro you can start your visit from Piazza Napoleone.
This square, dedicated to Napoleon, was realized by his sister in 1806, while she was ruling Lucca. In order to create this square many buildings were destroyed.
In this square stands Palazzo Ducale. It was part of a fortress which had been destroyed. Only this building survived and in the XV century it was enlarged by Paolo Guinigi. Since then it has been the political and administrative centre of the town.
In 1578 Bartolomeo Ammannati started its reconstruction: this intervention is still visible in the beautiful loggia that stands in the courtyard known as Cortile degli Svizzeri. This was once the façade.
Also the left side of the façade you see today was planned by Ammannati whose works remained unfinished.
The famous architect Filippo Juvarra designed the second courtyard.
During the rule of Elisa Baciocchi Bonaparte the square in front of the building was opened, just as it had been planned by the architects Lazzarini and Bienaimé, and the main façade of the building acquired its present aspect.
Now you can visit not only the courtyards, but also the wonderful staircase, the Statue Gallery, the Loggia and some of the halls.

Duomo (the Chatedral)

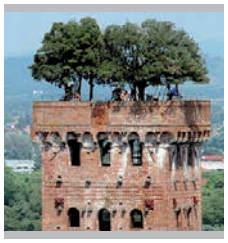
It was erected in 1060 and is dedicated to Saint Martin.
The façade was made in Romanesque style by Guidetto da Como in 1204. It is characterized by a porch with large arches and three levels of small loggias with decorated balusters, similar to those in the façade of the Cathedral in Pisa. These small columns, which are richly decorated, are made of green and white marble.
The church has a Latin plan and the beautiful Gothic interior is divided into a nave and two aisles with a transept of two aisles and a semicircular apse. It is covered by cross vaults.

Piazza Anfiteatro

This square lies where once was the Roman Amphitheatre. This building, built between the I and the II century, was at that time outside the walls. It could contain over 10,000 spectators. It was covered with marble and decorated with columns. It was abandoned during the barbaric invasions.
In 1830 Lorenzo Nottolini uniformed the buildings erected randomly on the site of the old amphitheatre giving the square the plan it has today. Nottolini maintained the buildings of different heights and opened a street giving a unique appearance to this square.
The only part of the Roman amphitheatre left today is the arch on the left through which you enter the square. The other arches in the square were erected in the last century.

Piazza San Michele

It has been the centre of the town since Roman times, when the Forum was here.
The Church of San Michele, Palazzo Pretorio and Palazzo del Decanato all stand in this square. In front of the church is the birthplace of the famous composer Giacomo Puccini. The building houses the Museum and the Foundation which are dedicated to him. The church you see today was started in 1100 AD and finished only in the XIV century. The façade is clearly Romanesque in the lower part, while the upper part is Gothic, just like the church of San Martino
The cusp is adorned with a statue representing San Michele, the saint who the church is dedicated to. In the right corner of the façade you can see a beautiful "Madonna with the Child" by Matteo Civitali.
This part of the façade was restored in the last century, when it was also enriched with effigies of important men of the time, such as Cavour, Garibaldi and others.



Case Guinigi and Guinigi Tower

These buildings represent a marvellous example of Medieval architecture in Lucca. The «Case Guinigi» were a group of mansions and towers where one of the most important families of the town, the Guinigis, lived.
Today only one of the four original towers still survives and you can visit it. It is 44.25 metres tall and was made with brick sandstone. It was started in 1384.
From the top of the tower, where 7 holm-oaks grow, you can enjoy a wonderful view of the town and the countryside.
The loggia and the porch on the ground floor of the tower has been closed, and so have the stone arcades which characterized the mansions. Fine mullioned windows are in the upper level of these buildings.

PISA

A short walk around the ancient Medieval walls through a beckoning arch and we can see Piazza dei Miracoli a breathtaking magnificence of the square .
The Cathedral, the Baptistery , the Leaning Tower and the Monumental Cemetery have stood stately in the dazzling splendor of their marbles for over a thousand years.

The Leaning Tower

The construction begun in 1173 and it must have been suspended at the completion of the third ring, around ten years later, since a subsidence of the soil of between 30 and 40 cm. had thrown the tower out of the perpendicular, causing an initial overhang of circa 5 cm. More than a century after the laying of the foundation stone, was once again begun (1275) by Giovanni di Simone, who added three more levels, correcting the axis of the Campanile. In 1284 the six stories of loggias were to all effects finished, bringing the height of the building to 48 m., and employing a technical expedient that was meant to diminish, at least optically, the effects of the inclination, accomplished by raising the galleries of the upper floors on that side.
At the time the inclination of the Tower was more than 90 cm.
The tormented vicissitudes of the Tower did not, as one might expect, greatly worry those who were involved in the construction and completion.
The long intervals between building activity were dictated, most likely, by the need of letting the Campanile 'rest', but above all by letting both the foundations and the ground on which they rested settle down.
In a certain sense it can be said that the subsidence of the soil and the consequent inclination had, on the whole, been foreseen. At the beginning of the 14th century the bells were placed at the sixth level, in the large opening still visible in the marble cylinder beyond the loggia. Between 1350 and 1372 Tommaso di Andrea Pisano (according to Vasari) terminated the installation of the belfry on the summit of the sixth order of loggias, increasing the correction of the axis, and thus diminishing the load on the side that was in inclination, which in the mean while had become fixed at 1.43 m.
Conceived of not only as a bell tower, but also as a belvedere for the square below - from the earliest times the loggias have served as 'grandstand' for religious events and fairs - it rises 58.36 m above the level of the foundation, just under 56 m over the level of the countryside, and its inclination, measured at the base, is over 4 m. The average subsidence of the base is 2.25 m, while the progression of the overhang, despite all attempts so far made to bring it to a halt, is about 1.2 mm per year.

The Cathedral

The Cathedral of Pisa is an inseparable part of marvelous four-piece ensemble of masterpieces of architecture and art which makes the Piazza dei Miracoli what it is. The group of buildings so scenographically set in the piazza del Duomo of Pisa leave the visitor with an impression in part real and in part unreal, like a fairy tale, due first and foremost to the striking contrast of the white marble with the green lawn and blue sky.
In Roman times the Palatium of Emperor Hadrian stood here and subsequently a place of worship dedicated to Santa Reparata was built on top.
In 1063, after the victory of the Pisan fleet in Palermo, Buscheto di Giovanni Giudice was entrusted with the task of building the cathedral, which was to be the perennial glorification of the splendor of the Maritime Republic. Pope Gelasius II was present at its consecration (26.09.1118), and the subsequent enlargement was terminated around the middle of the 1120s. At the turn of the century Rainaldo, a native of Pisa, finished the luminous façade.

THE BAPTISTERY

In size and aspect the Baptistery, an imposing construction with a circular ground plan and dedicated to St. John the Baptist, is, together with the Cathedral, the Tower and the Camposanto Monumentale, one of the local points of the Piazza dei Miracoli. Construction was begun in 1152 by Diotisalvi in Romanesque style.
It was continued about a century later by Nicola Pisano who added the airy loggia with its Gothic embroidery of triangles and aediculas, the setting for sculpture from the workshop of Nicola and Giovanni Pisano.
The finishing touch to this marble gem is the dome, terminated in the 14th century, covered with tiles and lead plaques and crowned by a bronze figure of the Baptist.
Of the four portals, the one on the east which opens onto the splendid façade of the Cathedral, is the finest and artistically

most elaborate. The jambs are decorated with beautiful relief of pure Byzantine inspiration which depict, on the right, the Apostles, the Ascension and David, while on the left a trenchant series of the Months. The lintel is divided into two tiers; in the lower one is a description of Episodes in the life of St. John the Baptist, in the upper one, Christ between the Madonna and St. John the Baptist with Angels and Evangelists alternating.

SIENA & SAN GIMIGNANO

SIENA

Siena is situated in the very heart of Tuscany at 70 km. from Florence and 231 km. from Rome along the Cassia Way. She a lies at 322 mt. above sea level on top of three hills overlooking the Arbia and the Elsa valleys. The uneven level of the ground affords suggestive views and most interesting perspectives. Previously an Etruscan city and Roman settlement, it has known economic and artistic prosperity during the Middle-Ages. Siena has been able to conserve its ancient medieval characteristics integrally: buildings, small squares, narrow streets and best of all, the warm rich colour of red bricks. The town is divided into seventeen districts called "Contrade ".
It is rich in works of art and monuments as:

The Cathedral

Beautiful building with a dark green and white Gothic-Roman facade. It hosts many works by Donatello, Pisano and Arnolfo di Cambio.
Some frescoes by Pinturicchio.
The inlaid marble floor is a real masterpiece made by famous artists

Museum Opera del Duomo

It is near the Cathedral. On the ground-floor it hosts ten statues by Pisano and a lot of paintings, jewelry and illuminated manuscripts, which come from the Cathedral. Many important works by Pisano, Jacopo della Quercia (Madonna with Child). On the first floor the museum exhibits the greatest masterpiece of the Sienese school of painting, the famous "Maestà", by Duccio di Buoninsegna.

Battistero di San Giovanni

On the right side of the Cathedral. It preserves the fifteenth-century baptismal font by Jacopo della Quercia. It seems that Donatello and Ghiberti also participated in creating this wonderful work. Rich interior with many frescos and works of art.

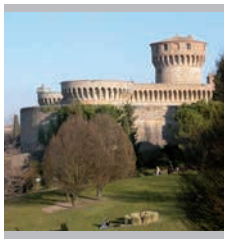
Piazza del Campo and Siena's Palio

This is one of the most beautiful piazzas of Italy and perhaps of the world. It is shaped like a large shell, paved with red bricks and divided into nine sections. This is the square where Sienese meet, the center of city life and government. It is dominated by the Tower, built in 1848 and 102 mt high, from which it is possible to admire the panorama of the entire city, with its towers, gates, narrow streets and red brick houses.
Twice a year, the famous Palio of Siena takes place here.
Next, the Palazzo Pubblico (Town Hall) built between 1297 and 1342, represents an important example of Gothic architecture in Tuscany. The Palace is well conserved and on the ground-floor it hosts many frescoes by Sano di Pietro, Vecchietta, Simone Martini, Sodoma. On the first floor of the Civic Museum many works are preserved including the frescoes "Guidoriccio da Fogliano" and the "Maestà", fine masterpieces by Simone Martini.

SAN GIMIGNANO

San Gimignano is situated halfway between Siena and Florence. It is a town that today still preserves its ancient medieval layout. It had great importance and economic growth during the Middle Ages, thanks to the Via Francigena, the ancient way walked by pilgrims who went to Rome from Northern Europe.
San Gimignano is known as the "Città dalle belle torri" (The town of beautiful towers) and appears like a delightful medieval panel painted with and architectonic scenery nowhere else to be found. In the past it had up to 72 Tower-houses, and today 14 have survived until the present day. San Gimignano contains many remains and several works of 14th and 15th century Italian art, especially of the Sienese and Florentine schools. Piazza del Duomo is the heart of the town, it hosts the Palazzo del Podestà,
The Palazzo Comunale (Town Hall) and the Duomo. During the centuries Piazza del Duomo represented the central point of San Gimignano where each celebration took place and where the municipal power seat. On the square rise two towers, Torre Grossa and Torre Rognosa.

Nowadays it continues to preserve its ancient role and is one of the focal points of the town.
Duomo, Basilica di Santa Maria Assunta Three nave aisle church dating back to the 12th Century. The rich interiors with frescoed walls by famous painters contribute to make this church a unique testimony of its ancient past..
Works of art by Bartolo di Fredi, Taddeo di Bartolo, Ghirlandaio and ligneous sculptures by Jacopo della Quercia
Town Hall: It overlooks Piazza del Duomo with its tower, called "Torre Grossa", 52 mt high, the highest tower of the town, from which it is possible to have a wonderful view. It hosts the civic museum with many works of art. Of note are the "Annunciazione" by Filippo Lippi, (1482) , the "Crucifix" by Marcovaldo (1260) , the tabernacle of Santa Fina, the patron saint of San Gimignano and "Madonna in Gloria" painted by Pinturicchio in 1512. Of particular interest is the "Sala di Dante" where visitors can admire the "Maestà" by Lippo Memmi, painted in 1317. Several other frescoes.
Palazzo del Podestà : dates back to 1239. It is characterized by a stone and brick facade and by a high tower called "La Rognosa". Inside, on the central wall, is "Madonna con Bambino" (Our Lady with child) , a nice fresco by Sodoma
Sant' Agostino: Gothic Romanesque church built in 1280 characterized by a very nice marmoreous altar by Benedetto da Maiano. It is one of the most beautiful Renaissance works of art. On the walls, several frescoes by Pollaiolo and Ghirlandaio. (Madonna with child) . The principal work is represented by the frescoes of the choir painted by Benozzo Bozzoli between 1461 and 1464 showing the life of St. Agostino.
Piazza della Cisterna: Beautiful piazza in a triangular shape. Nice travertine well in the center of the square covered in a red brick pavement. From here many of the severe buildings can be admired.



VOLTERRA

Volterra is one of the most known town in Tuscany: its unique position and its ancient history leave everyone enchanted.
It is located on a hill 550 m above the sea level.
An uncontaminated landscape surrounds the town: it's the ideal place for excursions on foot, on horse back or by bicycle. Volterra's history dates back from the Etruscan period to the 19th century with artistic and monumental traces of great importance.
Volterra is prevalently Medieval and yet cherishes abundant evidence of the Etruscan period: thePorta all'Arco (the Etruscan gate) which date from the 4th century B.C., the Acropolis, the defensive walls which are still visible in parts of the town.
The Roman period is attested by the important remains of the Teatro di Vallebona which date back to the Augustan period, the Baths and an enormous rectangular water cistern.
The Middle Ages are not only visible in its urban structure but too in its buildings, its house-towers and churches: the Palazzo dei Priori, a 13th century building, the Palazzo Pretorio, the Cathedral (12th century), the Baptistry (13th century) streaked with Volterran stone, the conventual Church of San Francesco with its adjacent chapel of the Croce di Giorno, the Church of San Michele and of San Alessandro .
Apart from its monuments, its art and history, Volterra also offers a magnificent panorama of the gentle undulating hills of the surrounding landscape abruptly interrupted in the West by the Balze (crags).
Volterra is not yet touched by the stress of contemporary life and visitors who come to Volterra have the immediate impression of stepping into the past, of being in a particular place with its narrow Medieval streets and the enigma of its Etruscan origins.
Volterra is famous even for an artistic handicraft unique in the world: the manufacture of Alabaster.

VINCI

Vinci offers visitors the chance to see many places connected to Leonardo's life.
Behind the castle of the Conti Guidi, in the small but lovely center of town, you will notice a wooden representation of the Vitruvian Man, a drawing by Leonardo in which he represented a man with the ideal proportions. From this terrace, you can enjoy a wonderful panorama of the surrounding hills.
The Leonardo Museum is arranged in two buildings which cover the history of the master both as architect and scientist. There are rooms dedicated to his building-site machinery, textile manufacturing technology, mechanical clocks, war machinery, flying machines and much more. You should also have a look at the Church of Santa Croce (of the Holy Cross) where Leonardo da Vinci was baptized and at the bronze monument sitting in Piazza della Libertà called Leonardo's Horse.
Anyone interested in learning much more about Leonardo can visit the documentation center specializing in his works at the Biblioteca Leonardiana. The home of Leonardo isn't found within the town of Vinci, it is just outside its center on the foothills of Montalbano in a village called Anchiano. Here, Leonardo da Vinci was born on April 15, 1452 as an illegitimate child of a domestic servant and Sir Piero da Vinci, owner of the house at that time.
As you arrive here, you can feel in the air the deep connection that exists between Leonardo and those landscapes and the impossibility of separating them. The gentle hills, the wide fields of vineyards and olive trees and the sun itself are integral parts of the museum and of its history: this beauty has doubtless contributed to envelope and influence the fantasy, wits, creativity and genius of one of the greatest men in the world.

PISTOIA

Pistoia is a very pretty town you can visit in half a day. It is often off the beaten path, because travelers focus on the most known cities in Tuscany

The historic center of Pistoia is not accessible to traffic, and this is great, because you can really enjoy the town.

Start your walk from the large and bright square in Pistoia where there are the Cathedral of San Zeno, the Bell Tower, the Baptistery, the Town Hall and the Court.

The Cathedral of San Zeno was built around the X century. It was destroyed by fires and then was renewed around the XII century. On the facade there are the statues of the two patron saints of Pistoia: San Zeno and San Jacopo. It seems that the bishop Zeno got to the city of Pistoia an important relic of San Jacopo from Santiago de Compostela.

Inside the Cathedral you will find one of the most beautiful piece of artwork: the silver altar of San Jacopo (also the famous Italian artist Filippo Brunelleschi worked on it between 1287 and 1456) and a crypt. Under the presbytery there are the remains of the original church and a stunning Roman villa.

On the right of the Cathedral you will see a unique brick building. It is the Palace of the Bishops (Palazzo dei Vescovi). In front of the Cathedral there is the ancient Baptistery of San Giovanni in Corte, dating from the XIV century, which has a typical Romanesque architecture. It has a marble facade.

From the square head to Ospedale del Ceppo, in Piazza Papa Giovanni XIII, just a 10-minute by foot. This hospital was built in the XIII century and witnessed the outbreak of the Black Death that struck Pistoia in 1349. On the top of the hospital there are beautiful glazed earthenwares made by the brothers Della Robbia.

The legend tells that in one of the heads is hidden the formula used by the brothers to produce this particular ceramic, which has the advantage of keeping its color unchanged over the years. This is still a mistery!

The Garzoni Garden and The Butterfly House

Near Pinocchio Park you can visit: the Garzoni Garden and the Butterfly House

The Garzoni Garden is one of the most beautiful gardens in Italy: manicured walkways, flower beds, fountains with traditional water games and towering statues will accompany you along a charming and, at the same time, relaxing walk.

The Butterfly House is a large greenhouse where you'll find an exotic garden populated by thousands of colorful tropical butterflies.

Buggiano Castello, Buggiano

On the road from Montecatini Terme to Pescia is the village of Borgo a Buggiano, from which a side road leads up to the old walled village of Buggiano Castello . Its most notable building is the 13th century Palazzo Pretorio, its facade covered with 15th and 16th century coats of arms. In the small square stands the Romanesque parish church, originally built in 1038 for a Benedictine abbey and later partly rebuilt. The aisles are separated from the nave by columns with antique capitals (on the right) and pillars (on the left); fine marble sculpture and wall-paintings.

The Cinque Terre

The Cinque Terre (literally: Five Lands) is a part of the coastline of the Italian region Liguria that comprehends five villages: Riomaggiore, Manarola, Corniglia, Monterosso and Vernazza.The hillside that surrounds these towns is the portion more uncontaminated and charming of this region, therefore the villages, the coastline and the hillside has been a natural reserve since1997 to preserve this reign made of wild scents, and they are part of the UNESCO world heritage list. The coast could appear as inhospitable because it's rocky and steep but it is rich of charming bays, beaches and wonderful panoramic paths that waits only to be discovered. But the Cinque Terre isn't only seaside, in the hillside it hides beautiful medieval villages, sanctuaries, workshops and typical dishes

Riomaggiore

The village of Riomaggiore rise between two craggy hills that slopes into the sea. It is particular with all its little colored houses built vertically and its really suggestive to have a walk in these alleys, where lights and shadows create very particular effects. The originality of Riomaggiore's houses is due to the fact that each one has two entry: one is at level of one street the other is at level of the upper street. The houses had this particular structure since 1500 to allow a fast escape route in case of Saracenic raids. In Riomaggiore starts the well known Via dell'Amore, a paved path dug into the rock, that finish in Manarola. The path is wonderful, you'll walk among nature hearing the sound of waves breaking on the rocks. Riomaggiore is a shy town, that makes slowly discover itself, revealing little by little its Castello sul colle di Cerricò, that has a beauty panorama overlooking the sea, or the church of San Giovanni Battista.

Manarola

Manarola is a delicate colors picture, reign of the olive trees, with a characteristic village where the houses look like the natural prosecution of the narrow and long cliff. In the high part of the town there's the church of San Lorenzo, built in 1338 in Gothic style, with three beautiful naves and baroque interiors. You must not miss the "White bell tower"an ancient watchtower, the ancient San Rocco Hospital and the Oratory of Disciplinati della Santissima Annunziata dated around 1400. Clearly the sea lovers won't be disappointed: going down in direction of the beach you'll find a lot of corner from which you'll enjoy a breathtaking view.

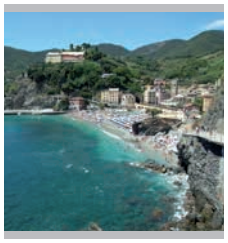
Corniglia

The ancient Roman village of Corniglia is situated on an impressive cliff about 100 meters high. It's the only town in the Cinque Terre that can't be reached from the sea. Therefore to reach Corniglia is necessary to walk up the "Landarina", an exhausting brick flight of steps or, if you prefer, you can follow the vehicular road that, from the station, leads to the village. The name of the town "Corniglia" comes from the name of a Latin farmer "Corneliu" who produced the well known white wine, already famous at Romans time. In the delightful village you could visit the Gothic church of San Pietro and the XVIII century square "largo Taragio" with the Oratory of Santa Caterina, that stands over the houses.

Vernazza

Vernazza is situated on an impressive cliff, nowadays is a calm seaside village but, in the past, it was the harbor from which the boats, that was charged to protect the coasts from the Saracens, sailed.

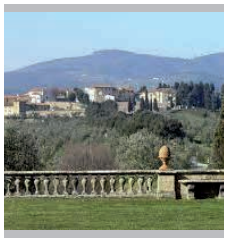
The magical atmosphere of this village is going to charm you: mysterious alleys, hidden among the little and lovely red, yellow and pink houses, that in the summertime become crowded of tourists coming from all the world. Vernazza is considered one of the hundred most beautiful village of Italy and it preserves its maritime vocation, therefore we suggest you to reach this town by sea to see at once the beautiful port starred by delicate colors houses. After then you can visit the church of Santa Margherita of Antiochia and the remains of the ancient fortress: the towers of the XI century and the Doria's castle, the tower of the friary of Padri riformati di San Francesco and the tower Belforte. The wonder Sanctuary of Nostra Signora di Reggio has a tree-lined square that will invite you to meditation and relax. It isn't easy to reach the Sanctuary, you'll have to walk a wild road among the nature.



Monterosso

Monterosso maintains its maritime tradition and it still has signs of the past sea battles: the medieval tower that now is the bell tower of San Giovanni Church, the castle that overlooks the sea with its three round towers, and the Aurora tower, the only one survived of thirteen towers that protected the village. Once you arrive in Monterosso's narrow and labyrinthine alleys you could choose if you want to spend your time in the "centro storico" of the town, where the church of San Giovanni Battista stands over, or you can stay in the modern Fegina with its equipped beach . Moreover Monterosso's sandy beach is the biggest of the Cinque Terre.

WINE TOUR & DINNER AT TENUTA CAPEZZANA



Wine jars and tasting cups found in Etruscan tombs dating to approximately 1000 BC show that vines have been cultivated in Carmignano since Pre Roman times. More specifically, a parchment rent contact conserved in the Florence State Archives, dated 804, reveals that vines and olives were cultivated at Capezzana for the production of oil and wine as early as 1200 years ago.

In the early Renaissance, Monna Nera Bonaccorsi built the first "Nobleman's house" and nine farmhouses together with wine making buildings at Capezzana. In the Eighteenth century the wife of Marquis Bourbon enlarged the estate and increased the number of farms.

Numerous generations and families followed until to the Contini Bonaccossi.

Today the estate has 670 hectares of which approximately one hundred are vineyards and one hundred and forty olive groves.

Capezzana estate is one of the authentic jewels of this region, a small hamlet of houses with a majestic main Renaissance villa where the Contini-Bonacossi family lives.

Adjacent farm, historic cellars beneath this complex which date to the Sixteenth century, a modern olive mill and a huge "vinsantaia" (where vin santo is made) above the cellar.

Capezzana location explains the uniqueness of its climate: the altitude (approximately 200 mt above sea level) is such that daytime temperatures in summer are high whereas nights are cool on account of the winds off the Apennines. These conditions ensure good maturing of the grapes which are generally one to two weeks ahead of other Tuscan wine growing regions. Rainfalls is well distributed throughout the year because the mountains cause condensation activity that generally provides some rainfall in June and July interrupting the dry season.

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