

## **Patient Safety Exploratorium Faculty**

### **Karen Dunn PhD, FRACP, MBBS.**

**Karen Dunn** is a paediatrician with many years of experience in the field of quality and safety at the Children's hospital, Melbourne. She has particular interest in understanding the nature of adverse events involving paediatric patients, the role of medical emergency teams, human factors in patient safety and the role of the healthcare worker in rescuing patients from harm. The latter forming the basis of her PhD thesis.

**Peter Lachman** joined Great Ormond Street Hospital and the Royal Free Hospital in 2005 as he was taking up a Health Foundation Improvement Fellowship at the Institute of Healthcare Improvement (IHI) in Cambridge Massachusetts. While in Boston he studied at the Harvard School of Public Health graduating with a Masters in Public Health. He spent time at IHI learning about the intricacies of quality improvement and safety from the leading theorists in the field. He trained as a paediatrician in South Africa and from 1987 worked at the Red Cross War Memorial Children's Hospital in Cape Town, as Director of the Child Development Clinic and Senior Consultant Paediatrician and Senior Lecturer in Child Health at the University of Cape Town. From 1994 to 1996 he was Consultant Paediatrician at Queens Hospital NHS Trust Nottingham, before moving to Northwick Park Hospital NHS Trust to be part of North West London Hospitals NHS Trust. He stayed at NWLH NHS Trust for almost 9 years and during that time was Designated Doctor for Safeguarding Children for Harrow, Clinical Director for Children's Services, Clinical Director for Women's Services and Deputy Medical Director. His current interests are in transforming health care organisations to become safer and more effective. His clinical commitments in neuro-disability and chronic care are at the Royal Free.

**Dr. Stephen Muething** is a pediatrician and Associate Professor at the University of Cincinnati and Cincinnati Children's Hospital Medical Center. He was in private pediatrics in a small community in Indiana for 13 years before returning to join the full time faculty in 2000. Dr. Muething became a leader in Quality Improvement and Transformation at Cincinnati Children's. He has graduated from Dr Brent James' Advanced Training Program in Salt Lake and Advanced Improvement Methodology at Cincinnati Children's. He has led improvement work of the acute care systems including improvements in evidence-based care and patient flow. He was a leader of the team that began Family-Centered Rounds. Dr. Muething also serves on several expert panels for improvement and is the Improvement Advisor of a national collaborative to reduce bloodstream infections secondary to central venous catheters. Dr Muething serves as a hospitalist at Cincinnati Children's. He is now Assistant Vice-President of Patient Safety and Patient Safety Officer and has a special interest in design for reliability and high reliability organizations.

**Matt Scanlon** is Assistant professor, Pediatrics (Critical Care) at the Medical College of Wisconsin; and previously was patient safety officer at the Children's Hospital of

Wisconsin. Matt's research interests include Patient safety, human factors, usability, quality measurement, quality improvement, bar coding, technology assessment, systems design and engineering and epidemiology of pediatric critical care.

**Polly Stevens** is the Director of Quality and Risk Management at the Hospital for Sick Children in Toronto, a position she has held since the fall of 2000. Prior to joining Sick Kids, she held clinical, quality improvement, and risk management roles in Alberta, British Columbia, and Ontario. She has a Diploma in Respiratory Therapy, a Bachelor of Administrative Studies degree, and a Master of Health Science in Health Administration degree. She has also completed the Patient Safety Leadership Fellowship program of the American Hospital Association and the National Patient Safety Foundation. At Sick Kids she has been instrumental in developing a culture of patient safety and ensuring a "systems" approach to managing adverse events.