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# Patient Safety Symposium: Issues, Analyses, Prevention

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## Instructor's Guide

**List of all the resources included in the submission.**

1. 6 Powerpoint Presentations
    1. Introduction: Patient Safety Symposium
    2. Communication Skills & Conflict Management
    3. Error Disclosure & Apology
    4. Root Cause Analysis
    5. Second Victim Recovery
    6. Patient Safety Symposium Summary
2. 1 Case Scenario
3. Table worksheet for symposium with fishbone 9 2011
4. Video of Error Disclosure & Apology to case scenario patient and wife. This provides faculty with an illustration of an error disclosure scenario. It may also be used during the course if standardized patients are not available.
5. Video from Harvard excerpts: Scott, Pronovost, Scott
6. Evaluation forms:
    1. Pre-Test, Post Test (content)
    2. Symposium Evaluation (process)
    3. Reflection Paper

**<u>Explanation of when, how, and the order in which to use each resource file.</u>**

See SAMPLE COURSE AGENDA with ASSIGNED RESOURCES

**The purpose/goal of the resource.**

To introduce the concept of patient safety and the process of insuring patient safety and preventing medical errors.

To discuss patient safety from an interprofessional perspective.

To create a culture of interprofessional cooperation and communication while introducing the skills needed to ensure patient safety.

To provide the opportunity for interprofessional students to practice, integrate, and synthesize knowledge applied to analyzing patient safety and preventing medical errors.

To appreciate the different approaches and the valuable input that their student colleagues provide.

**The conceptual background.**

The Symposium is designed as an introduction to patient safety for students of multiple health professions, presented as an opportunity for them to interact with students from various programs in a classroom setting for preparation to function on interprofessional teams in their future clinical practice.

Patient safety education in the US is limited. Literature search reveals a dearth of information about patient safety education and specifically IPE. Curriculum change at a national level has been slow regarding patient safety, in spite of the IOM report several years earlier (Blumenthal D, and Ganguli I, 2010). Based on a survey of "clerkship directors in Internal Medicine at U.S. and Canadian academic medical schools in 2006 …only 25% of institutional members reported that their schools had explicit patient safety curricula" (Alper 2009). Some think that "the process of making significant moves towards a patient safety (PS) culture requires changes in healthcare education" (Milligan 2007). After surveying almost 5000 new graduates in medicine (1779), nursing (2196) and pharmacy (521) to assess their self-reported patient safety competence, authors concluded that "large-scale efforts are required to more deeply and consistently embed patient safety learning into Health Practitioner (HP) education. However, efforts to embed PS learning in HP education seem to be hampered by deficiencies that persist in the culture of the clinical training environments in which we educate and acculturate new HPs" (Ginsburg 2013). Based on this one may postulate that interprofessional active learning would improve the learning experience.

The literature is replete with assessments of the status of interprofessional education and recommendations yet it remains an elusive target with a promising future.

In 2001 the Institute of Medicine (IOM) "recommends that patient safety programs … establish interdisciplinary team training programs, such as those involving simulation, that incorporate training designed to improve and maintain skills, as well as improve communication among team members" (Greiner A.; Knebel, E., 2001).

In 2003, the IOM issued a report that stated that "health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team…" and furthermore that patients received safer, high quality care when health care professionals worked effectively in a team, communicated productively, and understood each other's roles (Greiner A.; Knebel, E., 2003).

In 2011, an expert panel, the Interprofessional Education Collaborative delivered a report "Core Competencies for Interprofessional Collaborative Practice" that stated that the goal of … interprofessional learning is to prepare all health professions students for deliberatively working together, with the common goal of building a safer and better patient-centered and community/population oriented U.S. health care system."
It seems safe to conclude that the traditional learning model of didactic teaching offered in separate uni-professional silos will not accomplish a goal of effective teams. Additionally, active learning has many advantages over didactic teaching. Students are more involved and engaged, there is greater emphasis on development of student skills rather than information transmission, there is greater emphasis placed on the exploration of attitudes and values; students are more motivated, they can receive immediate feedback, and are involved in higher order thinking (analysis, synthesis, evaluation).

> "One must learn by doing the thing, for though you think you know it-- you have no certainty until you try" (Sophocles, 5th c. B.C.) (Bonwell).

Several programs at Jefferson have not included patient safety in their curriculum. Examples of this are Physical Therapy, Occupational Therapy, and Radiologic Science. Some programs have several course, e.g Pharmacy students on drug related errors. Medical students have a half day on medical errors. However there are no interprofessional activities based on patient safety/medical errors existed.

Poor communication between professionals has been implicated as one of the predominant causes for medical errors, especially communication between doctors of different ranks and hand offs between professionals. These factors suggest a pressing need for a cultural shift where medical persons are encouraged to discuss errors—a culture where they feel safe to have discussions, hierarchies are not dominant, and there is no assigned blame. The hope is that through learning, discussing, and practicing team and communication strategies, students will carry with them the trust and respect

for the professionals with whom they work to translate this to prevention of errors and ultimate improvement of patient care.

After a review of the literature and assessment of the Jefferson curriculum, we concluded that there is a need for patient safety training that is interprofessional, and emphasizes communication skills and the culture of healthcare teams to promote patient safety. In addition, it is clear that students learn best through active learning. Thus, this course is designed so that each learning module consists not only of didactic information, but in activities that engage the students, reinforce basic material, and promote interaction between the professions. Additionally, this interaction helps the students learn to appreciate the skills and knowledge that members of each profession bring to the team.

**Design of the Course:**

Students are seated in groups made up of representatives of various health professions to enhance interprofessional interaction, which is the thrust of the course. While learning the basics of patient safety, students learn the contributions that members of the various health professions can make to patient safety. We stress the importance of interprofessional interaction, communication, and team process related to patient safety. The course revolves around a case scenario presentation of a hypothetical patient who had his knee replaced and is the victim of a series of medical errors with consequent Deep Vein Thrombosis and Pulmonary Embolism.
Throughout four course modules, students receive didactic information to provide foundational knowledge followed by a related interactive interprofessional learning activity for application, practice, and synthesis of the basic principles presented. The learning activities range from viewing and discussing impactful DVD monologues to simulation of exploring a medical error and analyzing its root cause. While students view a simulation they empathize with the live actors playing the role of a patient who is the victim of a medical error, his protective wife, and the challenged healthcare practitioners who must disclose the error to them.

**Course Modules and Learning Activities (LA):**

I. **Culture of health team-Communication/conflict management:** Presentation of team communication skills (based on Team STEPPS© language) and interpersonal conflict management techniques –LA: identify communication issues in the case scenario that contributed to the medical error; role play team communication skills and interpersonal conflict

management techniques to the case scenario.

II. **Root Cause Analysis-System problems:** Presentation of the theory behind and methods of root cause analysis –LA: Construct Fishbone of the root causes of errors in the case scenario –LA: List corrective actions for the identified causes of the errors.

III. **Error disclosure:** Presentation of the rationale for Error Disclosure, the value and effectiveness of Error Disclosure, and the proper technique for Error Disclosure. –LA: observe a demonstration of a standardized patient and wife in an error disclosure meeting with health professionals (a video file of the enactment of an error disclosure is included.) This should be followed by questions from students, commentaries of strengths & weaknesses of the disclosure and suggestions for modifications.

IV. **Second Victim Trajectory:** Introduction to the concept of the emotional impact of a patient's bad outcome on the second victim, the involved health professional. –LA: video monologues illustrating the emotional impact of this; explaining second victim trajectory and the need for development of a structured program to ensure emotional peer support of the second victim.

The session concludes with a summary and a brief discussion of what the students think a "changed culture" would look like. What would allow this culture change to occur to make it safe for someone to discuss mistakes and near misses? The students complete the session by filling out their post-test based on content, evaluation of the session based on process, and an individual reflection paper.

**Practical implementation advice.**

Students who attended the symposium had some clinical experience so that they could relate to the issues of patient safety and medical error. During the session, the students are seated in groups made up of representatives of each health profession to enhance inter-professional interaction, which is the thrust of the course.

At the beginning of the course as part of the introductory Powerpoint, the speaker engages the students by eliciting from students their experience with errors, whether they would report an error, the implications of reporting, and how to report.

Scheduling any interprofessional course can be challenging when trying to coordinate the schedules of students whose various curricula may be on different timetables. It is important to have buy-in of faculty and teaching administration to ensure cooperation with scheduling of students. Ideal implementation would include faculty incorporating the concepts of patient safety into existing curricula to introduce and reinforce the information. This linkage to a course would demand some grading requirement to emphasize to students and faculty the importance of the material and the experience. Thus, some of the didactics could be decreased in the symposium providing more opportunity for interprofessional interaction.

**How has it been successfully deployed?**

The course has been presented to 305 students in the schools of medicine, nursing, occupational therapy, pharmacy, physical therapy and radiologic sciences at Thomas Jefferson University. The session was 4 hours, occurring monthly over an eight-month period.

**What are the limitations of the resource?**

Since students came from different disciplines and different programs, their knowledge base of patient safety was variable. This created a challenge when deciding at what level to teach. Teaching to those with little knowledge of patient safety may have left the more advanced learner disinterested. Although this was the first interprofessional patient safety experience for all students, some of those who had been taught patient safety in their own discipline were less satisfied with the course.