

Patient Safety Curriculum

Module I Practical Approaches to Patient Safety

Medical Error Scenarios and Perspectives on Patient Safety

Workshop Leaders Guide

Introduction to Module I
Medical Error Scenarios and Perspectives on Patient Safety**NOTE TO INSTRUCTOR:**

This module is designed to support a lecture presentation and group discussion. It contains 42 PowerPoint slides and a suggested script suitable for presentation as is, or with your own adaptations. You should customize your presentation based on your audience's educational needs and on your own experience with patient safety topics as reflected in this module.

Learning Objectives

Upon completion of this module, participants should be able to

1. Identify the medical errors portrayed in three global scenarios.
2. Define the following terms as they relate to patient safety:
 - error
 - adverse event
 - preventable adverse event
 - proximal cause
 - root cause
 - slip
 - lapse
 - mistake
3. Recognize the difference between the sharp end and the blunt end of a health care system, and the relationship of each to medical errors.
4. Cite examples of success stories in system safety.
5. Describe the key elements of a root cause analysis.
6. Recognize the benefits of automation and information technology with regard to patient safety.
7. Recognize key features of nationwide and Massachusetts-based patient safety organizations and initiatives.

Presentation Outline

Topic	Slide #
1. Introduction.....	1 – 3
2. Global Scenarios	4 – 10
3. Perspectives on Patient Safety	11 – 13
– Federal Mandates for Quality Improvement (IOM Reports).....	14 – 16
– Dimensions of Quality.....	17
– Pathophysiology of Error.....	18
– Systems Thinking.....	19 – 24
4. Success Stories in Safety	25 – 27
5. Framework for Identifying Errors.....	28 – 29
6. Understanding the Current System	30
7. Designing Systems for Safety.....	31
– Automation and IT Systems.....	32 – 33
8. Medication Safety Programs.....	34 – 36
9. Nationwide Safety Initiatives	37 – 39
10. Initiatives in Massachusetts	40
11. A Few Simple Rules for Health Care in the 21 st Century	41
12. Conclusion	42

Guidelines for Presentation and Discussion

This module is designed to support a lecture presentation and discussion for residents and practicing physicians. It sets the stage for the entire curriculum by presenting three global scenarios in which medical errors and adverse events occur. This module also addresses strategies for improving patient safety, including sections on the role of error reporting, success stories in safety improvement, and systems thinking.

Make sure that the following resources are available and in working order for this session:

- the CD-ROM containing the PowerPoint slide presentation of Module I
- hardware necessary for displaying the slides
- a flipchart and markers for noting comments during your question and answer sessions
- handouts for each participant (*be sure to bring enough copies of the forms*)
 - an attitude survey (*distribute before the session*)
 - a presentation evaluation form (*distribute after the session*)

You should give participants an opportunity to discuss how the scenarios may relate to situations they see in their own practices. Use the flipchart for noting the participants' remarks and suggestions for safety improvements.

Evaluation Forms

On the next two pages are forms for the participants to complete when they attend the curriculum and want to obtain CME credit (1.0 hour for Module I).

Attitude Survey

This anonymous survey is meant to assess the participants' attitudes toward issues in patient safety improvement. Participants should complete this survey before the session. If you have the opportunity to review the completed surveys before the session, you can tailor your presentation to address key issues revealed in the surveys. Keep in mind that patient safety improvement and medical errors are sensitive subjects that some participants may be reluctant to discuss. Remind participants that the purpose of this curriculum is not to complain or point fingers, but to explore opportunities and global strategies for the improvement of patient safety.

Presentation Evaluation Form

This anonymous evaluation form gives participants an instrument to rate the presentation with regard to its ability to provide new knowledge and skills, its relevance to clinical practice, and its overall educational value. It also includes queries regarding participants' suggestions for improvement and other comments.

Attitude Survey

(Each participant should complete this survey before the session, after the session if necessary.)

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. The IOM Report accurately estimates the number of deaths due to medical errors.	1	2	3	4	5	6
– the IOM figures are an overestimation	1	2	3	4	5	6
– the IOM figures are an underestimation	1	2	3	4	5	6
2. Physicians should participate in medication safety programs.	1	2	3	4	5	6
3. Medical errors happen in hospitals, not in ambulatory care.	1	2	3	4	5	6
4. Practice of evidence-based medicine can improve patient safety.	1	2	3	4	5	6
5. Voluntary error reporting and analysis is a good way to begin improving patient safety.	1	2	3	4	5	6
6. The benefits of computer-based systems (for medical records, etc.) outweigh the barriers to their adoption.	1	2	3	4	5	6
7. I use or plan to use a computer-based prescribing or tracking system in my practice.	1	2	3	4	5	6
8. Patient safety initiatives underway on a national or local level will have a significant impact on my practice.	1	2	3	4	5	6

Presentation Evaluation Form
(to be completed after the session)

Please rate this presentation in terms of its ability to provide you with the following:

Scale: 1 = needs a lot of improvement 2 = Needs some improvement 3 = Okay 4 = Good 5 = Very good 6 = Exceptional

	1	2	3	4	5	6
A. Knowledge of...						
forces driving initiatives to improve patient safety	1	2	3	4	5	6
relationships of systems thinking to clinical practice	1	2	3	4	5	6
characteristics of high-reliability systems	1	2	3	4	5	6
issues relating to the use of IT systems	1	2	3	4	5	6
patient safety initiatives underway nationally or locally	1	2	3	4	5	6
B. Clinical relevance...						
raised issues that I have seen in practice	1	2	3	4	5	6
focused on an important topic likely to affect my practice	1	2	3	4	5	6
provided me with new knowledge or skills	1	2	3	4	5	6
provided practical suggestions I can apply in my practice	1	2	3	4	5	6

How would you rate the overall value of this session? (circle one)

Poor Fair Okay Good Very Good Excellent

Comments and suggestions for improvement:
