Patient Safety Workforce Training

Susan Carr

Editor
Patient Safety and Quality Healthcare

Primary researcher and writer
Train for Patient Safety

Quality Colloquium • August 21, 2005

Patient Safety and Quality Healthcare

- www.psqh.com

- A bi-monthly magazine published by Lionheart Publishing.

- Feature articles, columns and news items by and for all stakeholders.

- Train for Compliance
www.trainforcompliance.com

- Train for Patient Safety
www.trainforpatientsafety.com

ABQAURP www.abqaurp.org

TRAIN FOR PATIENT SAFETY

Train for Patient Safety Announces a Content Partnership with the Patient Safety Officers Section of the American Board of Quality Assurance and Utilization Review Physicians to Prepare a Comprehensive Patient Safety Improvement, Medical Errors Reduction and Healthcare Quality Enhancement Training Curriculum

ABQAURP

Train for Patient Safety

- Basic Concepts in Patient Safety I & II
- Medication Safety
- Joint Commission and Medicare Safety Initiatives
- Clinicians
- Non-clinicians
- Ambulatory Care Environment
- Patient Responsibility

Comprehensive On-line Course

- Course objectives and summary
- Approximately 30 lesson pages per module
- In-text test questions
- Final multiple-choice test for certificate

Where to Begin?

- Problem of scale: global concepts and fine details, complex and simple
- Definitions: What do we mean by error, mistake, systems, safety?
- Where are we now?
- What approach will insure success?

Culture of Patient Safety

- Safety is the first priority
- Encourage reporting
- Learn from errors
- Transparency of information
- Pervasive communication
- Migration of authority

Systems Approach to Safety

"Individuals are responsible for the quality of their work, but focusing on systems rather than individuals will be more effective in reducing harm."

Morath & Turnbull, *To Do No Harm*

Systems Approach to Safety

- Do not attempt to prevent all errors from occurring.
- Prevent errors from causing harm to patients.
- Support individuals by enhancing their performance.

Systems Approach to Safety

"Systems approach substitutes inquiry for blame and focuses on circumstances rather than on character."

Morath & Turnbull

The "New Look"

- Network of theory and linked empirical findings from:
  - Cognitive engineering
  - Cognitive anthropology
  - Social research on systems
  - Management research
  - Naturalistic decision making

The "New Look"

"Two Years Before the Mast:
Learning How to Learn About Patient Safety"
by Richard Cook, MD

Published in the proceedings of meeting organized by the NPSF at the Annenberg Center for Health Sciences in California in 1998.

Learning How to Learn — Cook

1. Learning about safety is not continuous but occurs at intervals.

   Accidents, emergencies, changes in conditions,

Learning How to Learn — Cook

2. Learning requires dissonance between belief and experiences.

Impossibilities, surprises,

"out of the box" experiences

Learning How to Learn — Cook

3. Not everyone learns at the same time.

Based on need, experience
May create dissonance

Learning How to Learn — Cook

4. Learning is not always sequential.

Depends on where you begin: different roles, training, experience, trigger points

Learning How to Learn — Cook

5. Learning does not necessarily produce appreciation for the consequences of what has been learned.

Hindsight is easy, and concepts such as Reason's Swiss Cheese model are easier to understand than implement.

Learning How to Learn — Cook

6. Learning about safety is not permanent.

Strive for continual experience-based learning

Learning How to Learn — Cook

7. Learning about safety requires close contact with failure and also the distance needed for reflection.

Experience, analysis, and reflection are learning tools.

Learning How to Learn — Cook

8. Learning recapitulates the sequence of research that comprises the New Look.

The value of earlier work in this field.

Learning How to Learn — Cook

9. Learning inherently involves exploring the "second stories" that lie behind accidents and failure.

Dig deeply for details in the story. Complexity must be honored. Value the story.

Learning How to Learn — Cook

10. Learning about safety exposes organizational stress.

Budgets, limited resources, hierarchies, priorities, change

Learning How to Learn — Cook

11. Learning about safety begins with learning that people make safety.

Human performance is the "critical resource" in efforts to improve safety. Technology and processes should enhance, not constrain human performance.

Cook & Woods' Paradox

People are simultaneously the source of success and failure in safety.

Safety is a "chronic value under our feet that infuses all aspects of practice."

Basic Principles of Patient Safety I

I.   The Origins of the Patient Safety Movement

II.   Who Is Responsible for Patient Safety?

III. Terminology

IV.   Factors that Contribute to Error and Injury

V.   Leadership and Patient Safety

VI.   Quality Improvement Programs and Management Practices for Patient Safety

Basic Principles of Patient Safety II

I. Knowledge Management and Information Technology

II. Reporting Safety-Related Incidents

III. Investigation Systems for Patient Safety

IV. Organizations that Promote Patient Safety: Private Sector

V. Organizations that Promote Patient Safety: Public Sector

Medication Safety

I. Scope of the Problem

II. Terminology

III. Data Collection and Error Reporting

IV. Opportunities for Medication Errors

V. Preventing Medication Errors

VI. Use of Technology

Joint Commission and Medicare Safety Initiatives

- Becoming Safer
- Moving Toward Safety
- Safety Initiatives
- Patient Identification
- Transferring Information

- Medication Safety
- Medical Equipment
- Reducing Infections
- Medication Continuity
- Everyday Safety

Patient Safety for Clinicians

I.   The Patient Safety Imperative for Clinicians

II.   The Concept and Culture of Safety

III.   Definition of Error

IV.   Liability, Disclosure, and Apology

V.   Improving Patient Safety

VI.   Clinical Information Technology (IT) Systems

Patient Safety for Non-clinicians

I. The Non-clinician's Role in Patient Safety

II. Executives and Senior Management

III. Patient Safety Officers, Risk Managers, and Quality Improvement Professionals

IV. Other Non-clinical Stakeholders

V. Safety Improvement Tools