Patient Safety Workforce Training

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Train for Patient Safety

Patient Safety and Quality Healthcare

- A bi-monthly magazine published by Lionheart Publishing
- Feature articles, columns, and opinion pieces written by people working in healthcare
- Current sponsors are ABQAURP and the Healthcare Division of ASQ

Feature: Patient Safety Officers

- November/December 2005
- Brief first-person accounts about being a patient safety officer: primary concerns, biggest challenges and rewards, day-to-day routines, looking ahead
- Send submissions to susancarr@psqh.com

Complimentary Subscription

www.psqh.com

TRAIN FOR PATIENT SAFETY™

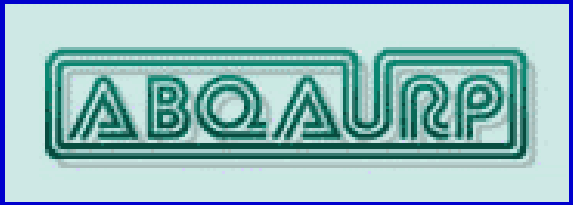
Setting the Standard for Compliance Education and Training in Patient Safety

- Train for Compliance
  www.trainforcompliance.com
  - HIPAA, Emergency Management, Pharmaceutical Compliance, Healthcare IT
- Train for Patient Safety
  www.trainforpatientsafety.com
- Demo version is available on Web site

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



Train for Patient Safety

- Basic Concepts in Patient Safety I & II
- Medication Safety
- Joint Commission and Medicare Safety Initiatives
- Patient Safety for Clinicians
- Patient Safety for Non-clinicians
- Ambulatory Care Environment
- The Patient's Role in Safety

Comprehensive On-line Course

- Course objectives and summary
- At least 30 lesson pages per module
- In-text test questions
- Final multiple-choice test for certification
- Inclusive reference list

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

1. Becoming Safer
2. Moving Toward Safety
3. Safety Initiatives
4. Patient Identification
5. Transferring Information
6. Medication Safety
7. Medical Equipment
8. Reducing Infections
9. Medication Continuity
10. Everyday Safety

Clinicians & Non-clinicians

Sharp End

- Direct interaction with hazardous situations
- Results of action are obvious, immediate, and attributable

Blunt End

- Indirect effect on safety, through systems and environmental factors
- Actions occur “upstream” and are less obvious

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 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

Ambulatory Care Environment

- Challenges that are specific to ambulatory care environments
- Technology
- Information systems

The Patient's Role in Safety

- Supply Information
- Communication
- Informed Consent
- Patient-Centered Care

Reflecting on My Learning

Learning about patient safety, writing the course, and staying current with new developments have been rewarding and challenging.

Where to Begin?

- Problem of scale
- Global concepts and fine details
- Multitude of programs and products
- What takes priority?

Systems Approach to Safety

"Safety does not reside in a person, device or department, but emerges from the interactions of components of a system."

To Err Is Human

Sources

- Richard Cook, MD
  Cognitive Technologies Laboratory
  University of Chicago
- David Woods, PhD
  Cognitive Systems Engineering Laboratory
  Ohio State University

Cognitive Technologies Laboratory

www.ctlab.org

Systems and Human Performance

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

Many Disciplines Contribute to Safety

- Cognitive engineering and ergonomics
- Human factors engineering
- Operations research
- Organizational science
- Naturalistic decision making

New Reference

Building a Better Delivery System: A New Engineering /Healthcare Partnership

- National Academy of Engineering
- Institute of Medicine

National Academies Press

www.nap.edu

Two Years Before the Mast

Learning How to Learn About Patient Safety

by Richard I. Cook, MD
National Patient Safety Foundation 1998

"…struggled to replace their old ideas with a newer more productive understanding of safety..."

Learning How to Learn

Learning about safety is not continuous but occurs at intervals.

Accidents, emergencies, changes in conditions, responses to new challenges

Learning How to Learn

Learning requires dissonance between belief and experiences.

Disturbance, surprises, “out of the box” experiences that challenge existing beliefs

Learning How to Learn

Not everyone learns at the same time.

Based on need and local experience; may create dissonance among departments

Learning How to Learn

Learning is not always sequential.

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

Learning How to Learn

Learning about safety is not permanent.

What is learned can be forgotten. Knowledge can become stale, inert, and inaccessible.

Strive for continual experience-based learning.

Learning How to Learn

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

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 stories told by clinicians at the frontline.

Learning How to Learn

Learning about safety exposes organizational stress.

Budgets, limited resources, hierarchies, priorities, change.

Learning How to Learn

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.

"Achieving high levels of performance does not flow from rooting out error, but rather through anticipating and planning for unexpected events and future surprises."

“Safety is not a commodity to be tabulated, it is a chronic value under our feet that infuses all aspects of practice.”