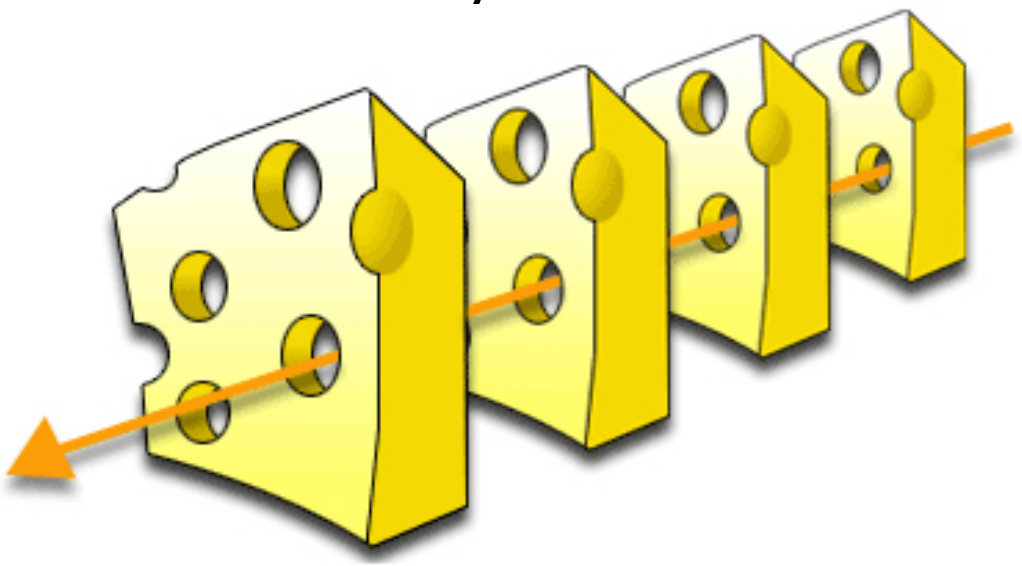
Improving Patient Safety: A System's Approach

Teachers of Quality Academy
Medical Education Day
April 22, 2015

Rationale/Need

- 44,000-98,000 deaths annually secondary to medical error
- 100,000 deaths annually from hospital-acquired infection
- Latent errors within the healthcare system



Rationale/Need

- BSOM Core Competencies includes Systems-Based Practice:
  - "**collaborate with other health care professionals** in providing team-based care"
  - "identify, analyze and propose solutions for **system errors** that impact the provision of patient care, in order to support the continued improvement of **patient safety**"
- No formal curriculum within the surgical clerkship to address this core competency

Collaborative Team Members

- Megan Sippey, MD

  General Surgery Resident, PGY3

- Gina Woody, DNP, RN

  Clinical Associate Professor, Adult Health Nursing

- Shannon Longshore, MD

  Surgery Clerkship Associate Director

- Carl Haisch, MD

  Surgery Clerkship Director

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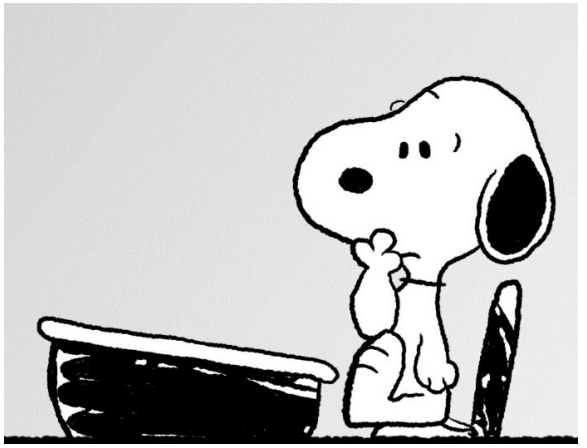
Methods/Description

- 3rd year medical students on the surgical clerkship and senior level nursing students
- Flipped-classroom model
  - "Framework for analyzing risk and safety in clinical medicine"
  - Reflect on a clinical experience in which a medical error occurred
- Brief (10 minute) lecture on patient safety
- Root cause analysis using a case study

Results



- Likert-scale evaluations

  (1=poor to 9=excellent)

  - Clear statement of objectives (8.7)
  - Clarity of presentation (8.7)
  - Organization of presentation (8.6)
  - Coverage of subject (8.7)
  - Clinical usefulness of topic (8.3)
  - Opportunity for questions (8.7)
  - Overall impression (8.6)

Results

- What was most beneficial?
  - "Interacting with people in other health professions and hearing their perspectives on team members' responsibilities"
  - "Understanding why […] presenting errors applies to all treatment team members"
  - "Talking about a real life situation and having nursing students present"

Results

- What was least beneficial?
  - "Case was very similar to IHI case"
  - "This does not help for boards"

Evaluation Plan

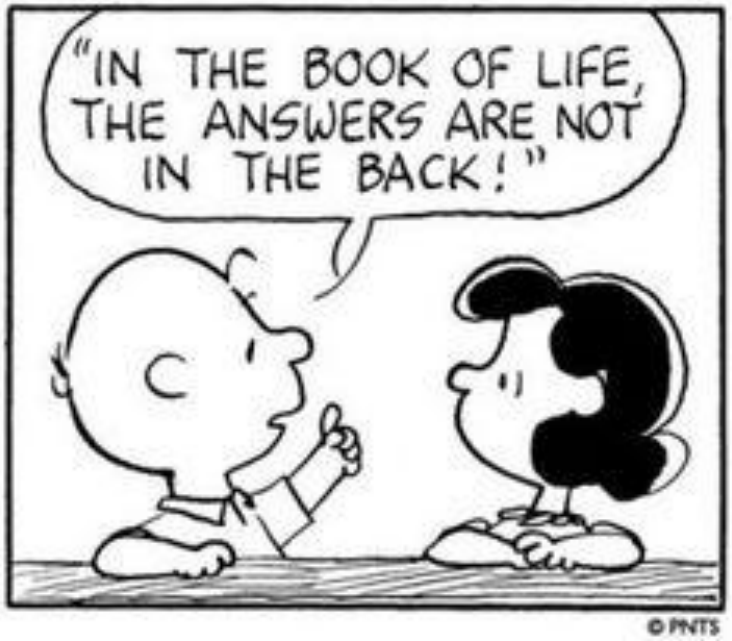
- Follow-up assignment:
  - Independent root cause analysis on a medical error or patient safety event witnessed during the surgical clerkship

Challenges Encountered

- Unable to change graded curriculum mid-year
- Scheduling

Lessons Learned

- Listen to and ask for feedback
  - Less reliance on fishbone diagram
- The more interactive, the better!



Next Steps

- Pre- and post-session Student Perceptions of Interprofessional Clinical Education-Revised (SPICE-R) Instruments
- Follow-up assignment for medical students next academic year

Acknowledgements

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