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

Team Leader Key Contact Info: sippeym@ecu.edu
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

- This project was completed with financial support from the American Medical Association (AMA) as part of the Accelerating Change in Medical Education Initiative. The content reflects the views of the authors and does not necessarily represent the views of the AMA or other participants in this initiative.

- Other acknowledgements: Thanks to Dr. Haisch, Dr. Longshore, and Gina Woody for their collaboration!