Patient Safety: The Elixir of Core Competencies

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Canadian Patient Safety Institute
Medical Education Rounds
McGill, October 18, 2007
Lecture that never happens..
IT SAYS HERE THAT THE RATE OF MEDICAL ERRORS IS STUNNINGLY HIGH.

THAT EXPLAINS MY Hysterectomy.
Competencies provide…

“a framework for curricular development based on a shared understanding of the essential knowledge, skills, and attitudes expected” of health care professionals.
Definition

- **Collaborative** practice is an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided (Way, Jones & Busing, 2000)
Introduction—Patient context
Transforming patient safety through education...

- How can health professions education impact on patient safety?

- What are patient safety abilities?

- The Safety Competencies Project
Video #2
What are the safety abilities of healthcare workers suggested by this scenario?
What are the safety abilities not suggested by the team in this video?

What competencies might they and others need?
Video 3
Communication
The Safety Competencies

Enhancing Patient Safety Across the Health Professions

Teamwork
Potential educational issues identified

- Lack of situational awareness
- Team fixation
- Non assertive communication
- Loss of leadership during crisis
- Loss of sense of knowing the urgency of the situation
- Unfamiliar with process of investigation
- Unable to support the reporting culture
- Unable to support a learning culture
- Unable to respond quickly when things are going poorly
The Draft Safety Competency Framework

- Domain 1 – Creating a Culture of Patient Safety
- Domain 2 – Working as a Team
- Domain 3 – Communicating Effectively
- Domain 4 – Using Safe Strategies to Enhance Practice
- Domain 5 – Managing Human Factors and Cognitive Processes
- Domain 6 – Managing High-Risk Situations
- Domain 7 – Responding to an Adverse Event
The last word is the Patient’s
The Safety Competencies

Enhancing Patient Safety Across the Health Professions
Project Plan

June – August 2006:

- Conduct environmental scan – including literature review, contacting key informants

- Develop and distribute a patient safety competency survey to Canadian faculties of medicine, nursing, pharmacy and other health professionals
## Patient Safety Education Survey

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>CONCEPTS (TOPICS)</th>
<th>TEACHING / LEARNING METHODS</th>
<th>EVALUATION</th>
<th>AUDIENCE / LEARNER</th>
<th>RATE YOUR PROGRAM</th>
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</thead>
<tbody>
<tr>
<td>IDENTIFY THE PATIENT SAFETY COMPETENCIES THAT SHOULD BE INCLUDED IN THE CURRICULUM</td>
<td>LIST EACH TOPIC AREA THAT SHOULD BE INCLUDED UNDER THE COMPETENCY AND PROVIDE A DESCRIPTION OR OUTLINE OF THE CONCEPTS THAT SHOULD BE INCLUDED</td>
<td>DESCRIBE HOW THE COMPETENCY SHOULD BE TAUGHT (INCLUDE EXAMPLES OF LEARNING STRATEGIES – E.G., REFLECTIVE JOURNALING, SIMULATION)</td>
<td>DESCRIBE HOW IT SHOULD BE MEASURED</td>
<td>SPECIFY THE PROGRAM AND THE YEAR WHERE THE COMPETENCY SHOULD BE INTRODUCED</td>
<td>IDENTIFY THE LEVEL FOR WHICH YOU FEEL YOUR PROGRAM HAS INCORPORATED THE COMPETENCY</td>
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<tr>
<td>Example: Medicating Safely</td>
<td>Actions, indications, contraindications and adverse effects of medications</td>
<td>Problem-based learning</td>
<td>Quiz (scenario based)</td>
<td>Undergraduate program 2nd year students</td>
<td>1 2 3 4 5 NOT AT ALL COMPLETELY</td>
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</table>
Patient Safety Themes

- Communication Teamwork
- Culture of safety
- Ergonomics
- High Risk Clinical Processes
- Cognitive error
- Human Factors
- Recognition and mitigation of hazards
Communication Teamwork

- Continuation of care between shifts / effective handoffs of patient care / *effective transfers of patient*
- Appropriate use of communication tools (i.e. SBAR, Crew Resource Management)
- Obtaining informed consent
- Cultural sensitivity / awareness
- Communicating risk
- Ensure written and verbal communication is clear *and accurate* to patients and family to prevent errors
- Ensure written and verbal communication is clear to other team members to prevent errors *(recording of information – documentation and charting)*
- Literacy for the providers (i.e. patient documentation, etc)
  - Use of acronyms
  - Disclosure
  - Authority gradient
  - Collaboration
  - Effective consultation
  - Conflict resolution
  - Knowledge of other team members’ competencies
- Acknowledgement of patient as a member of the team
Patient safety is a critical aspect of quality health care

...The reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes...
The Safety Competencies

- The Safety Competencies provide a framework of 7 core domains of abilities for all health professionals to incorporate into their work.

- By enhancing health professions education, The Safety Competencies will enhance patient care.
The Safety Competencies

- Domain 1: Creating a Culture of Patient Safety
- Domain 2: Working as a Team
- Domain 3: Communicating Effectively
- Domain 4: Using Safe Strategies to Enhance Practice
- Domain 5: Managing Human Factors and Cognitive Processes
- Domain 6: Managing High-Risk Situations
- Domain 7: Responding to an Adverse Event
The Safety Competencies

Domain 1: Creating a Culture of Patient Safety
The ability of health professionals to contribute to healthcare organizations, large or small, in ways that promote patient safety in their structure and function.

Domain 2: Working as a Team
The ability of health professionals to effectively collaborate with others to maximize patient safety and the quality of care.
Domain 3: Communicating Effectively

The ability of health professionals to effectively receive and convey information and facilitate the interpersonal and inter-organizational relationships needed to support safe and effective patient care.

Domain 4: Using Safe Strategies to Enhance Practice

The ability of health professionals to incorporate best practices in patient safety into daily activities.
Domain 5: Managing Human Factors and Cognitive Processes

The ability of health professionals to recognize the relationship between human performance and human and cognitive factors that may lead to adverse events.

Domain 6: Managing High-Risk Situations

The ability of health professionals to recognize, mitigate, and avoid common high risk clinical practices.
The ability of health professionals to recognize an adverse event when it occurs and respond effectively to mitigate harm, ensure disclosure and prevent it from happening again.
Domain 1: Create a Culture of Patient Safety

A patient safety culture is an essential ingredient to effectively implementing safer care. All health professionals require some expertise in contributing to such environments in the organizations in which they work. These organizations can be large or small, physical or virtual, but all can benefit from an effective safety culture.
Create a Culture of Patient Safety

Content in this domain includes, but is not limited to:

- Understanding of patient safety concepts, epidemiology, and basic theories
- Awareness of healthcare error
- Promote systems approach to care and safety
- Promote staff empowerment to resolve unsafe situations
- Role model and demonstrate a commitment to leadership in safety
- Ensure feedback on safety issues
- Integration of safety practices into daily activities
- Commitment to communication, teamwork, and quality
- Adverse Event reporting
- Commitment to just, non-punitive, culture
- Appropriate professional accountability
- Commitment to continuous learning and improvement
- Patient advocacy
- Commitment to best practices
- Engagement of all stakeholders in safety
- Promote non-punitive approaches to recognizing error
- Participate in patient safety education
- Promotion of self assessment and reflection on practice outcomes
Domain 2: Working as a Team

All health professionals need to be able to effectively collaborate interprofessionally and intraprofessionally within their practice context to provide high quality patient-centred care. Content in this domain could include, but is not limited to:

- Awareness of team members, their competencies, roles, expertise, and scope of practice
- Respect and professionalism
- Conflict prevention and management
- Effective handovers, transfers, and care transitions
- Shared authority and decision making, as appropriate
- Team learning, including setting team goals and measuring them
- Continuity of care
- Appropriate and effective consultation
- Team dynamics and authority gradients
- Feedback
- Debriefing / team support
Domain 3: Communicating Effectively

Effective communication is critical to many aspects of patient safety. Content in this domain could include, but is not limited to:

- Effective use of communication tools (e.g. “SBAR”) and technologies
- Informed consent and discharge
- Disclosure, reporting, and informing about adverse events
- Cultural competency
- Health literacy
- Describing risk
- Effective written and verbal communication regarding patient care
- Effective organizational communication systems
Domain 4: Using Safe Strategies to Enhance Practice

Safe practices have been identified and adapted from multiple domains of human endeavor to enhance patient care. Health professionals need to be able to incorporate those that are suited to their area of clinical activities and the organizational systems in which they work.
Domain 4: Using Safe Strategies to Enhance Practice

Content in this domain could include, but is not limited to:

- Hand hygiene
- Sound alike medications
- Medication reconciliation
- Proper medication preparation
- Proper patient identification
- Sterile technique
- Standard infection control and prevention precautions
- Equipment maintenance and proper placement
- Equipment assessment and training
- Checklists
- Adoption of practice guidelines
- Safe patient transport, handling, and transfers
- Injury prevention
- Removing physical hazards
- Patient monitoring
- Readbacks
Domain 5: Managing Human Factors and Cognitive Processes

Inherent in this domain is an essential understanding of the concept of human factors, clinical decision-making and cognitive processes. While all human beings can make mistakes, all health professionals need the ability to recognize, prevent, and mitigate the human aspects of error. Content in this domain could include, but is not limited to:

- Fatigue
- Shiftwork
- Stress and burnout
- Memory
- Hazardous attitudes
- Authority gradients
- Critical thinking
- Self-awareness and limits of expertise
- Awareness of scopes of practice
- Cognitive biases
- Clinician health and well-being
- Environmental impact on health professionals and their work
- Effective ergonomics and appropriate design of equipment, space, and environments
- Types of errors (e.g. Procedural, affective, cognitive)
- Human factors engineering
- Interaction of humans with systems, designs and technology
Researchers have identified some recurring, high-risk situations in patient care. Nosocomial infections and use of blood thinners are examples. Health professionals need to be able to recognize high risk situations and respond appropriately to prevent harm. Content in this domain could include, but is not limited to:

- Safe medication systems
- Blood products management
- Control of concentrated electrolytes
- Proper use of compressed medical gases
- Infection control strategies
- Effective emergency responses
- Prevention of falls, infections, and pressure ulcers
- Safe invasive procedures
- Protective devices and clothing
- Policies to incorporate new technology
Domain 7: Responding to an Adverse Event

All health professionals have a duty to recognize errors and adverse events, in their various forms, as they occur in their setting. They also have a duty to disclose adverse events and report events appropriately. Health professionals need to have the abilities needed to mitigate the impact of such events and prevent them from recurring. This requires an understanding of common causes of adverse events as well as near misses in systems of healthcare. This domain content could include, but is not limited to:
Domain 7: Responding to an Adverse Event

- Identification of adverse events
- Event analysis and response
- Adverse event/error reporting systems
- Incident analysis (e.g. Root cause analysis)
- Systems thinking
- Critical incident debriefing
- Commitment to continuous improvement
- Adaptability
- Hazard analysis
- Care of patients, families, and health professionals after an adverse event
- Communicating with media
- Disclosure
- Reporting of events including internal and external reporting structures
Tools for Interprofessional development

- Executive Patient Safety Series
- Patient Safety Officer course
- DVD multimedia product
- Simulation
- Campaigns/collaboratives; Safer Health Care Now /Hand hygiene
Positive Deviance

1. Don’t presume that you have the answer
2. Don’t think of it as a dinner party
3. Let them do it themselves
4. Identify conventional wisdom
5. Identify and analyze the deviants
6. Let the deviants adopt deviations on their own (don’t teach new knowledge—encourage new behavior)
7. Track results and publicize them
Canada’s Hand Hygiene Campaign

Campagne canadienne de l’hygiène des mains

www.handhygiene.ca
www.lavage des mains.ca
CPSI and TVC present........
DVD Trailer.....
Executive Patient Safety Series

Objectives:

- Describe how you can better fulfill your responsibilities and accountabilities for patient safety at the Board/Executive level;
- Understand the methods to effect a cultural shift in your organization to improve patient safety;
- Create and share safety practices that can be adapted and established in your organization; and
- Position safety in the context of quality in your organization.
Seven Steps to Patient Safety

1. Lead and support your staff
2. Foster a culture of safety
3. Promote reporting
4. Involve patients and the public
5. Implement solutions to reduce / avoid harm
6. Learn and share safety solutions
7. Integrate your safety management activity

Adapted from: National Patient Safety Agency for the National Health Service

“Seven Steps to Patient Safety – An Overview Guide for NHS Staff”

Canadian Patient Safety Institute  Building a safer Health System
Simulation

• Needs assessments via focus groups and retreats with Simulation leaders and industry experts
• Final stages of Grant approval from HC for protected envelop of funding to:
  – Create oversight group to co-ordinate simulation work nationally
  – Collaborate with professional schools and college to promote simulation as a educational tool for safety and the assessment of health providers.
Simulation
Inaugural Canadian Patient Safety Officer Course

September 2007
Background

- Canadian solution to accelerate incorporation of PSO into healthcare system
- Process: IHI Canadian Graduates Survey, Steering committee, themes and competencies, curriculum map, developed content and learning objectives
- Pre-course, in-residence and post course
- Virtual technology all phases
- Creation of web based primers
Educational challenges
Conclusion

- Patient Safety is the elixir of interprofessional competencies
Comments/Questions?
Change Models

- Positive Deviant

- [www.fastcompany.com](http://www.fastcompany.com)
- November 2000, Dorsey
- Gawande- Better 2007