Week 9: Plenary - Professionalism & Patient Safety

MANDATORY ATTENDANCE FOR ALL M1 STUDENTS

Thursday, November 19, 2009

10:30-12:20am

Room 423 CMW

THIS GUIDE IS STILL SUBJECT TO REVAMP FOR AY 09-10

Patient safety focuses on the avoidance, prevention, and amelioration of adverse outcomes or injuries caused by the processes of providing patient care. It is fundamental to health care practice and is a common goal of all health science professionals. Recently, patient safety and health care outcomes have emerged as central, public concerns. Since the release of the Institute of Medicine's (IOM) report entitled To Err is Human; Building a Safer Health System, there has been considerable discussion in both national and international arenas on ways to address these growing safety concerns. The IOM's report in 1999 conservatively estimated that up to 98,000 patients die every year from preventable medical errors in hospitals. This makes preventable medical error the third leading cause of death in the United States. In the IOM's follow-up report, Crossing the Quality Chasm: A New Health System for the 21st Century, the IOM strongly called for changes in current health care processes, systems, research and education that addresses the problems associated with safety and outcomes.

This educational module is designed to introduce first year medical students to basic concepts related to medical errors, patient safety and quality care outcomes. It also begins to create a foundation for the higher-level knowledge, skills and behaviors required to be a safe and effective health care provider.

OBJECTIVES:

After completing this module, students will be able to effectively and confidently:

- Define medical errors.
- Describe the importance of patient safety.
- Describe different types of medical errors seen in practice.
- Describe the current state of the health care delivery system.
- Describe the methods outlined in the Institute of Medicine's report "To Err Is Human" in reducing medical errors.
- Define the missions and work being done by leading the Joint Commission on Accreditation of Healthcare Organizations, including accreditation, performance measurement, patient safety, information dissemination and public policy initiatives.
- Define an adverse or sentinel event.
- Define the Institute of Medicine's (IOM) six aims for health care.
- Describe and discuss the IOM's 10 rules for redesign.
- Discuss the four main areas of redesigning the health care delivery system.
- Demonstrate knowledge and understanding of medication error crisis and opportunities for improvement.
- Describe methods to reduce medication errors.

PREPARATION:

1. Read the following four articles prior to the plenary. These articles will be used for group discussion during the plenary:

Click icons below.

Joint commission content 8_12_08.pdf IOM Crossing Quality Chasm exec summary1.pdf IOM Medication Errors Exec Summary1.pdf

IOM To Err is Human exec summary1.pdf

After reading the four articles, students are required to complete an online training course through the Confidence Based Learning (CBL) System. You will receive an email about a week before the plenary with a link to the on-line educational program that students are also required to complete before attending the plenary. The CBL System is designed to assess true knowledge (i.e., what you *actually* know vs. what you *think* you know.) This assessment is achieved through the CBL educational format, which determines your knowledge quality and your confidence in that knowledge. Once established, a personalized learning plan is created so that you can work toward closing any knowledge gaps and achieving mastery in the subject matter.

DURING THE SESSION:

1. Students will view a video on four clinical cases that illustrate the dramatic impact errors can have within the medical system and on health care providers.
2. Clinical case examples of common medical errors will be presented and discussed with students. Discussion will focus on: (a) how and why errors occur; and (b) how we can effectively manage risk when errors do occur.
3. Students will learn about and discuss different types of non-clinical and social skills that contribute to medical errors including disruptive personalities. Discussion will focus on how competencies in these types of skills could reduce errors, lower risk and improve patient outcomes.
4. An introduction to the current legal system will be discussed in relation to medical errors.

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