

**“Quality and Patient Safety”**  
**Summary of Current and Planned Course Activities**  
Eric I. Rosenberg, MD

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“Quality and Patient Safety” (QPS) is an eight semester required course for medical students that focuses on the epidemiology of adverse medical events, their impact on physicians and patients, and the importance of organizational safety and quality improvement. The rationale for such a course is based upon institutional, professional, and national calls to integrate patient safety training into undergraduate and graduate medical education. The objectives of the curriculum are to teach students about the impact of preventable, adverse medical events on patients, physicians, and other medical professionals; to prepare students to identify and participate in corrective strategies that improve quality and safety throughout their future careers; and to develop and nurture a culture of quality and safety at our institution that enhances patient satisfaction and quality of care outcomes.

QPS grows incrementally to parallel students’ gradual attainment of medical knowledge and clinical experience. Over 100 hours of patient safety-related instruction is now being delivered within the medical school curriculum by faculty. QPS I (the first-year course) was officially inaugurated in October 2008 with a presentation by the parents of a child who died at our institution as a result of a series of medication errors. Components of QPS II, III, and IV began in the fall of 2008. Students are currently evaluated by attendance, clinical skills exercises, and writing assignments. A future goal of the curriculum is participation in collaborative quality improvement projects. The objectives for the course activities outlined below [see table] were developed by an eleven member task force comprised of educators, senior administrators, clinicians, and a senior medical student. Many of the specific activities were created and continue to be refined through continuous collaboration with a variety of health sciences center faculty.

In the first year, students complete online modules that introduce basic terminology and concepts such as “error” and “quality.” Students attend patient safety grand rounds and workshops that emphasize patient and public concerns regarding threats to safety and the human impact of preventable adverse events. The second year of our curriculum will build upon core concepts taught in the first year to introduce specific safety and quality improvement methods. Students have attended pilot interprofessional workshop sessions focused on root cause analysis alongside nursing and pharmacy students will attend lecture and workshop sessions. Planned sessions for the 2009-10 year will include the impact of the tort system on quality improvement and ways to improve interprofessional communication. The third year capitalizes upon students’ clinical experiences to encourage discussion of actual critical or “near miss” incidents encountered during their clerkships. Students are encouraged to present possible system level improvements likely to reduce future adverse events. In the fourth year, students learn about the impact of polypharmacy on the elderly and ways to prevent patient falls. Students will demonstrate teamwork and communication skills by participating in adverse event simulation and

role-playing exercises, such as one focused on how to apologize and disclose appropriately an error to a patient.

Enthusiastic support from senior administrative leadership was essential to ensure rapid development and initiation of this curriculum. It remains a work in progress and continued collaboration with faculty already teaching, studying, and contributing to the improvement of patient safety and quality is crucial for the future success of the curriculum.

<b>Year</b>	<b>Current Course Activities</b>	<b>Planned Course Activities</b>
<b>I</b>	<p><u>Quality and Safety Grand Rounds</u>: “The Impact of Adverse Events on Patients and Families”</p> <p><u>Workshops</u>: “The Impact of Delayed Diagnosis and Treatment on Patients”; student observations of adverse events</p> <p><u>Online Modules</u>: “Adverse Events”; “Introduction to Quality Improvement”</p>	<p><i><u>Quality and Safety Grand Rounds</u>: “The Impact of Adverse Events on Clinicians”</i></p>
<b>II</b>	<p><u>Workshop</u>: “Root Cause Analysis”</p> <p><u>Online Modules</u>: “Introduction to Root Cause Analysis”</p>	<p><i><u>Lectures</u>: “The Tort System and its Impact on Quality Improvement”; “Improving Interdisciplinary Communication”</i></p> <p><i><u>Workshops</u>: “The Hidden Patient Safety Curriculum: Gap Between Ideal and Reality”</i></p>
<b>III</b>	<p><u>Ambulatory Care</u>: “Analysis of Critical/Near Miss Incidents”</p> <p><u>Pediatrics</u>: “Medical Student Safety Presentations”</p> <p><u>Internal Medicine</u>: “Systems Based Practice Elective”; “VA Patient Safety Rounds Elective”; “Morbidity and Mortality Conference Series”</p> <p><u>Psychiatry</u>: “Safety Clinical Conference”</p> <p><u>Surgery</u>: “Prevention of Foreign Body Retention”; “Morbidity and Mortality Case Conference Series”</p>	<p><i><u>Obstetrics/Gynecology</u>: “TeamSTEPPS Training”</i></p>
<b>IV</b>	<p>Emergency Medicine: “Device-Related Errors”</p> <p>Geriatrics: “Fall Prevention”; “Polypharmacy”</p> <p>Surgery: “Spotting Intraoperative Team Errors”</p>	<p>Workshops: “Disclosing Errors”; “Critical Care Incident Simulation”; “Disclosing Errors”</p>