

Developing a Four-Year Quality and Patient Safety Curriculum for Medical Students

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Problem

- Despite calls for integration of patient safety training into undergraduate medical education, few comprehensive safety and quality improvement curricula are available for medical students.

Objectives

- To improve students' understanding of 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.
- To develop and nurture a culture of quality and safety at our institution that enhances patient satisfaction and quality of care outcomes.

Description of Program

Year 1

- Quality and Safety Grand Rounds:** impact of medical errors on patients and families; impact on providers
- Workshops:** impact of delayed diagnosis and treatment on patients; student observations of adverse events
- Online Modules:** "Adverse Events", "Introduction to Quality Improvement"

Year 2

- Ethics:** "The Tort System and Its Impact on QI" (lecture)
- Ethics:** "The Hidden Patient Safety Curriculum: Gap Between Ideal and Reality" (Workshop IV)
- Pathology:** "Improving Interdisciplinary Communication" (lecture)
- Online Module III:** Introduction to Root Cause Analysis
- Online Module IV:** "Introduction to Quality Improvement"
- Workshop III:** Root Cause Analysis Exercise
- Workshop IV:** Quality Improvement Concepts

Year 3

- Ambulatory Care:** Analysis of Critical/Near Miss Incidents (Dr. Hatch)
- Pediatrics:** Medical Student Safety Presentations (Dr. Kelly)
- Internal Medicine:** Systems Based Practice Elective. VA Patient Safety Rounds or Analysis of Critical Incident
- Psychiatry:** Ethics/ Safety Clinical Conference
- Surgery:**
- OB/Gyn:**

Year 4

- Geriatrics:** Fall Prevention, Polypharmacy
- Simulation Exercises: Disclosing Error; Discussion of Errors on Rounds; Spot the Error in the O.R.
- Online Module V:** Disclosing Errors to Patients
- Online Module VI:** Anticipating Errors to Avert Harm
- Workshop VIII:** Presentation of QI Project
- Workshop XI:** Reflective Writing Review

Findings

- Year I course officially inaugurated 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 Year 2, 3, and 4 began in Fall 2008.
- Students are currently being evaluated by attendance at all required course activities, completion of clinical skills exercises, writing assignments, and eventual participation in collaborative quality improvement projects.

Lessons Learned

- Enthusiastic support from senior administrative leadership was essential to ensure rapid development and initiation of the curriculum
- It was crucial for the course directors to build collaborative relationships with faculty already teaching about safety and quality to unify the curriculum
- It was important to designate specific course directors and establish a distinct identity for this integrated course.

- "Quality and Patient Safety (QPS) I, II, III, IV".
- 100+ hours of instruction integrated into existing pre-clinical and clerkship curricula.
- Goals and objectives developed by 11-member faculty, student, and administrator task force from Dec. 2007 – May 2008.
- Two course directors (Rosenberg, Wears) each with 0.15 FTE assigned to course.
- Specific Activities:
 - QPS I: Online modules introduce basic concepts; patient safety grand rounds and workshops emphasize patient and public concerns re: preventable adverse events.
 - QPS II: Introduction to root cause analysis, quality improvement, and medical malpractice tort system.
 - QPS III: Discussions of adverse events and "near miss" incidents throughout clerkships; workshops discuss root cause analysis, prevention of retained foreign bodies during surgery; methods to improve interprofessional communication in clinical settings.
 - QPS IV: Workshops discuss fall prevention and polypharmacy in the geriatric population; planned activities include training in error disclosure and simulation of adverse events in critical care settings; quality improvement projects.