

Resident Education and Participation in Patient Safety

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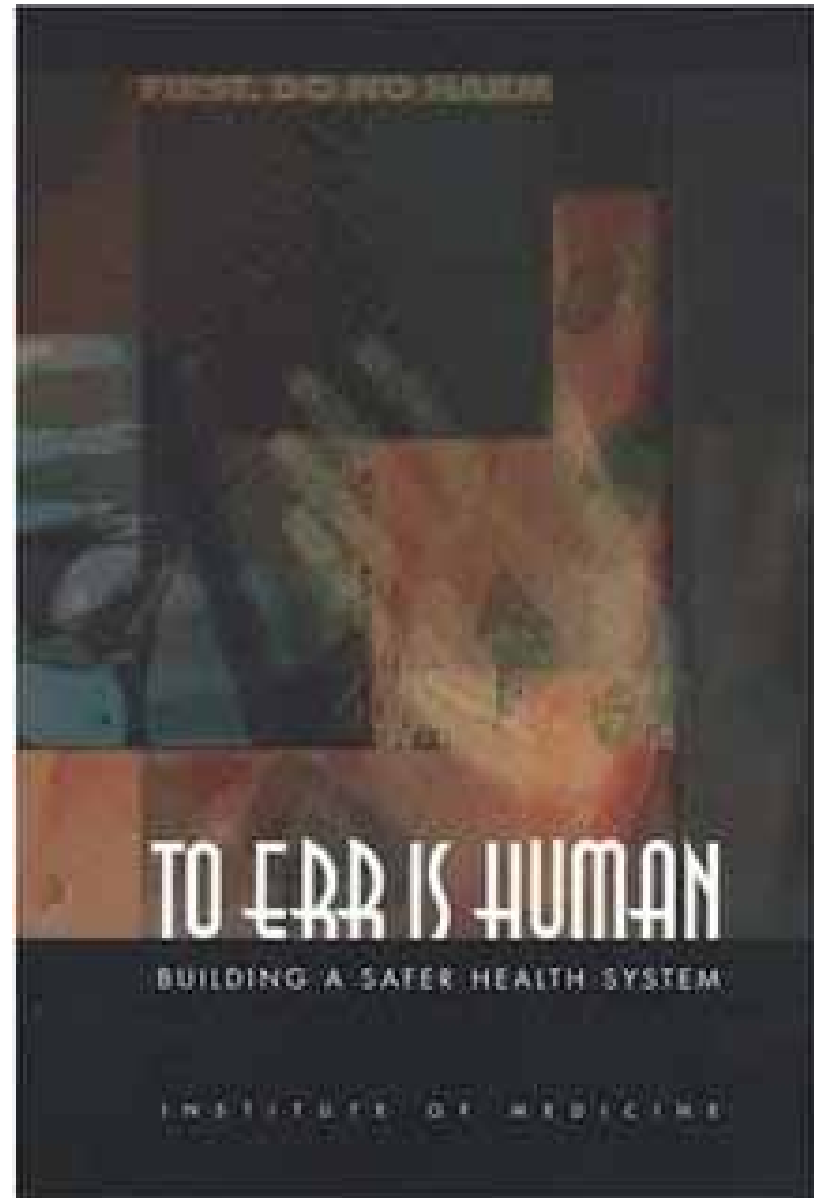
1/12/2010

VA Tuesday Morning
Conference

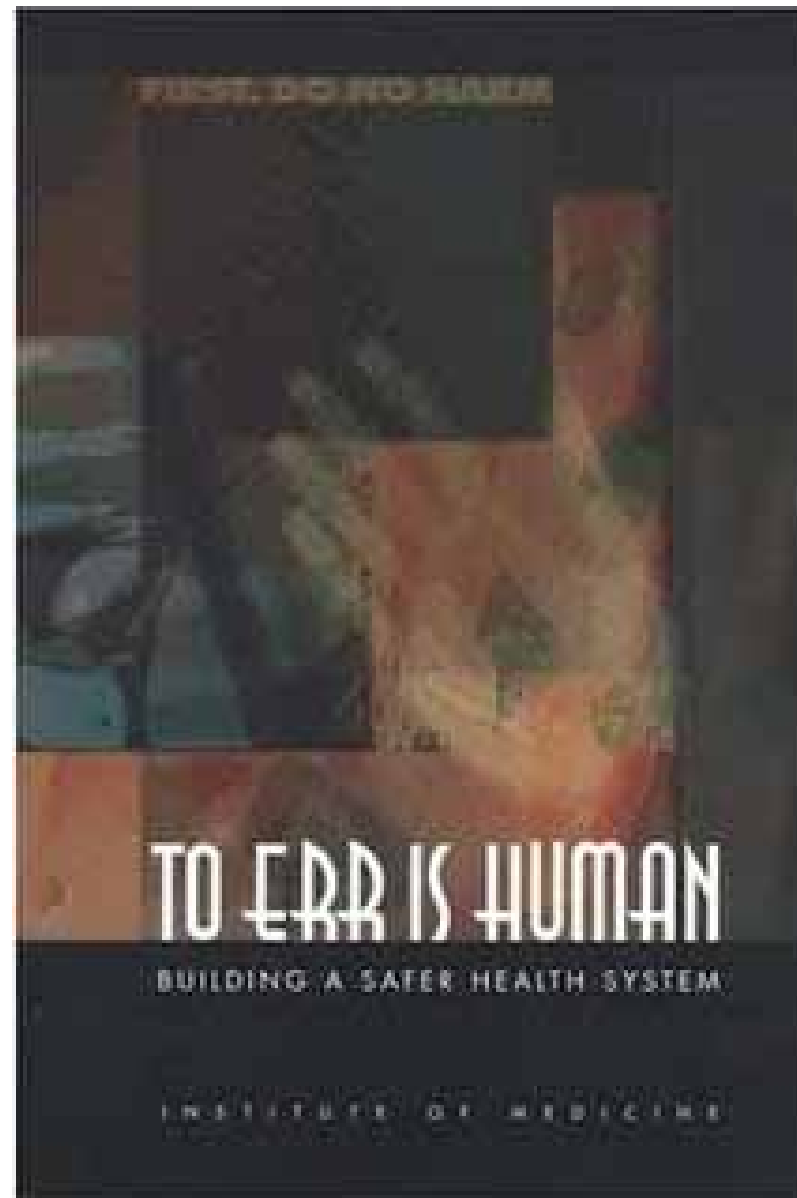
Objectives

- Review the start of the patient safety movement
- Define the scope of medical errors
- Review the ACGME core competencies as they apply to patient safety
- Outline the patient safety curriculum

- 1999 landmark report
- 3rd leading cause of death
- 44,000 – 98,000 patients per year
- Commercial jet every day



- It then laid out the basics of a plan to reduce the numbers of "preventable adverse events," a euphemism for medical errors.
- Gave rise to the patient empowerment movement
 - Reasons the reported deaths happened
 - Called for a shift from placing blame, to finding the reasons and fixing them
 - Outlined a series of proactive recommendations for doing just that

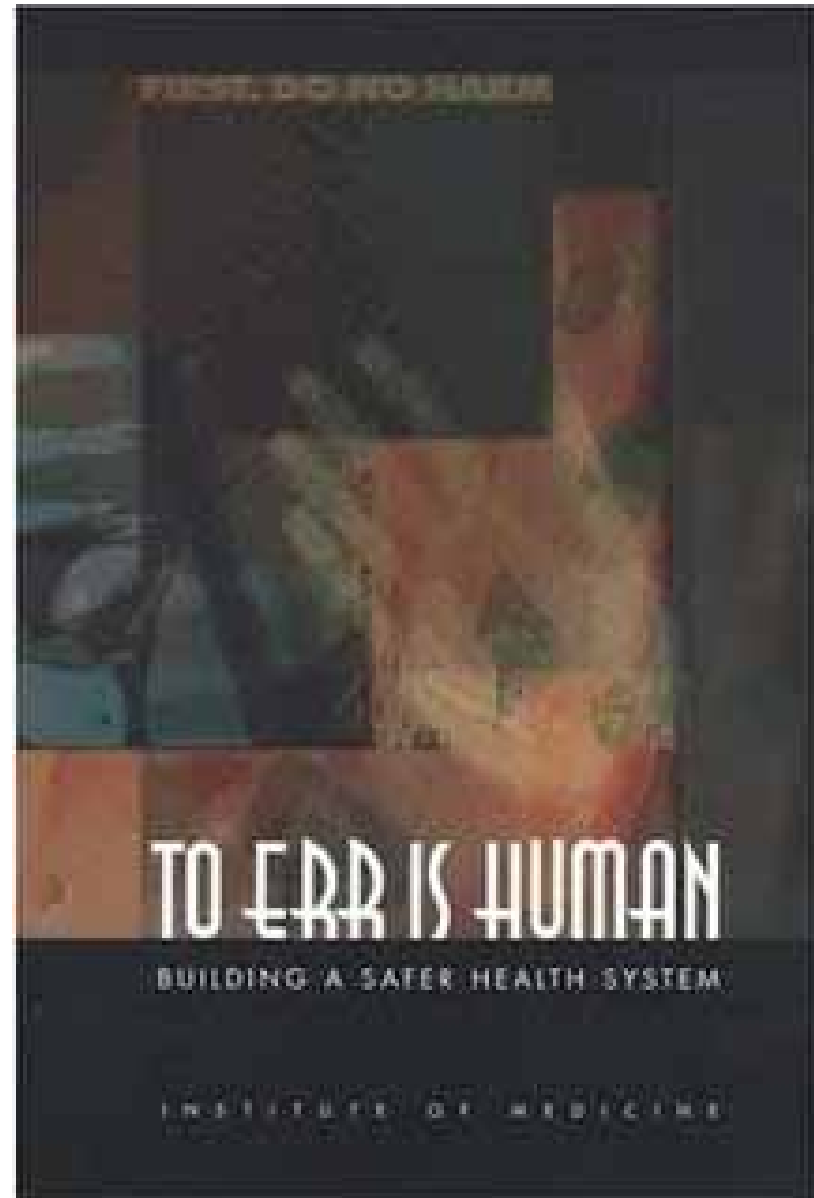


Shifting Blame

- Bad apple theory
- Targeting system issues



- IOM called for a complete overhaul of the healthcare system recommending “restructuring clinical education to be consistent with the principles of the 21st century health system throughout the continuum of undergraduate, graduate education of medical, nursing and other professional training programs.”



Residents and Adverse Events

- Survey of 640 trainees
- 55% had taken care of a patient with AE
 - 17.8% were within the week prior
 - 37% felt partially responsible
 - 8% had fatal outcomes

IM Residents

- 114/254 respondents – 45% (36% interns, 64% residents)
- Types of errors
 - Diagnosis (33%)
 - Prescribing and dosing (29%)
 - Evaluation and treatment (21%)
- Outcomes
 - 90% reported significant adverse patient outcomes, including death (31%)
 - Physical discomfort, emotional distress, additional therapy/procedure/stay

Wu A et al. Do House Officers Learn From Their Mistakes?
JAMA 1991;265:2089-2094.

Public View

- 42% affected by medical error
- 32% had permanent negative impact
- Bad apples vs. system issues
 - 65% thought it would be most effective to "keep health professionals with bad track records from providing care."
 - 69% thought the problem could be solved through "better training of health professionals."

Accreditation Council for Graduate Medical Education (ACGME)

- 6 Curriculum competencies in the Common Program Requirements
 - Patient care
 - Medical knowledge
 - Practice based learning and improvement *
 - System based practice *
 - Professionalism
 - Interpersonal skills and communication



Practice Based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- *(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;*
- *(2) set learning and improvement goals;*
- *(3) identify and perform appropriate learning activities;*
- *(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement*
- *(5) incorporate formative evaluation feedback into daily practice;*
- *(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;*
- *(7) use information technology to optimize learning; and,*
- *(8) participate in the education of patients, families, students, residents and other health professionals.*



PIF Question/Documentation

- Give one example and the outcome of a planned quality improvement activity or project in which at least one resident participated in the past year that required the resident to demonstrate an ability to analyze, improve and change practice or patient care.
- Describe planning, implementation, evaluation and provisions of faculty support and supervision that guided this process.

System Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- *(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;*
- *(2) coordinate patient care within the health care system relevant to their clinical specialty;*
- *(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;*
- *(4) advocate for quality patient care and optimal patient care systems;*
- *(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,*
- *(6) participate in identifying system errors and implementing potential systems solutions.*

PIF Question/Documentation

- Describe an activity that fulfills the requirement for experiential learning in identifying system errors.
- Describe the learning activity(ies) through which residents achieve competence in the elements of systems-based practice: work effectively in various health care delivery settings and systems, coordinate patient care within the health care system; incorporate considerations of cost-containment and risk-benefit analysis in patient care; advocate for quality patient care and optimal patient care systems; and work in interprofessional teams to enhance patient safety and care quality.

Patient Safety Curriculum



The Colorado Health Foundation™

Patient Safety Curriculum

- Modeled after University of Illinois Medical Center at Chicago and the University of Illinois Chicago College of Medicine “Full Disclosure” program
- 3 HealthONE residency programs:
 - PSL Transitional Intern program
 - Swedish Family Medicine Residency
 - Rose Family Medicine Residency

Started January 2009



Patient Safety Curriculum

- 10 -12 learning sessions
- Required patient safety event reporting
- Pre/post resident surveys
- OSCEs effective disclosure communication
- Participation in teams conducting root cause analysis
- Data collection on system improvements

Patient Safety Curriculum

- 10 -12 learning sessions
 - Monthly required noon conferences
 - Basics of Reporting
 - Adverse events, types of medical errors
 - How to report
 - » Reporting system
 - » Just the facts, no solutions
 - Mock Root Case Analyses
 - Family affected by medical error
 - End review of program and system changes

Patient Safety Curriculum

- Required patient safety event reporting
 - Analysis of current system
 - Development of paper system
 - 1 per month per intern
 - Placed in resident file

Patient Safety Curriculum

- Pre/post resident surveys
 - Attitudes on reporting
 - Attitudes on medical errors
 - Attitudes on disclosure with patients and hospital
 - Experience with errors

Patient Safety Curriculum

- OSCEs
 - Effective disclosure communication
 - CAPE
 - DVD for each resident file



Patient Safety Curriculum

- Participation in teams conducting root cause analysis
 - Patient Safety Committee
 - Multidisciplinary
 - Monthly meetings
 - Resident participation

Patient Safety Curriculum

- Data collection on system improvements
 - Documentation of improvements
 - Trend analysis
 - Patient safety committee improvements

Patient Safety Curriculum

- Our 1 year experience



Health
ONE
Presbyterian/St. Luke's
Medical Center
Special Care in the Heart of Denver

Pre-program Cumulative Summary

- 90.9% had not reported a medical error
- 60.3% did not know if their hospital or organization had an error reporting system
- 100% expressed interest in receiving training on how to disclose errors to patients
 - 63.3% very interested
 - 36.7% somewhat interested

Pre-program Cumulative Summary

- How did medical errors impact their life?
 - 77.8% experienced anxiety about future errors
 - 61.1% lacked confidence as a healthcare provider
 - 50% experienced job satisfaction
- 89.7% wanted to receive information and training about how to prevent serious errors that commonly occur.

Total Number of Reports

- 6 required per 6 months of each TY intern
- Goal: 144 reports
- Total reports this year: 98 (68%)

- 1st 6 months: 25/72 (35%)
- 2nd 6 months: 59/72 (82%)

What is being reported?

- 37 Medication related issues (38%)
- 11 Nurse communication/behavior
- 9 MD communication/behavior
- 8 Radiology
- 7 Reporting of results
- 6 Infection Control
- 3 Laboratory
- 3 Protocols
- 2 Other delay in treatment
- 1 Fall
- 1 Patient behavior

Patient Safety Committee

- Committee goals
 - Multidisciplinary
 - Monthly meeting with decision making capacity
 - Trend analysis of reports
 - System analysis of specific events
 - Accountability
- System improvements
 - Progress notes and orders

Patient Safety Committee

- Future goals
 - Intern attendance to discuss their reports
 - More multidisciplinary members
 - Increase physician/staff reporting
 - Disclosure team
 - Increase timing of reports

Post-program Cumulative Summary

- Attitudes on reporting
 - 16.67% less worried about disciplinary action
 - 33.3% less worried that their colleagues will not be supported
 - 12.5% less worried that they will be unfairly blamed

Post-program Cumulative Summary

- Free responses on reporting
 - That it is okay to report and talk about mistakes.
 - More likely to reports AEs in the future.
 - More proactive about reporting events, more aware of near misses and know they should be reported
 - I never knew how easy it would be to find cases of these before we were told to write them down. If this many are occurring in one hospital, then the actual magnitude must be huge.

Post-program Cumulative Summary

- Program satisfaction
 - Agreed or strongly agreed that the program is valuable
 - Agreed that they will be a champion for patient safety in their career
 - Agreed or strongly agreed that they will consider the safety record or safety culture of the organization they choose to practice

Post-program Cumulative Summary

- Attitudes on medical errors
 - 16.6% improvement that they agree or strongly agree that medical errors are one of the most serious problems in health care
 - 50% improvement that medical errors are usually caused by failures of care delivery systems not failure of individuals
 - 17% improvement that serious errors should be reported (100% agree or strongly agree)
 - 100% knew about our reporting system

Conclusions

- Patient safety curriculum
 - can provide residents with tools and vocabulary to talk about mistakes, accountability, disclosure and apology
 - Connect residents to actual adverse events and solutions within their system
 - Provide insight into the need for “beyond blame” of individuals to address system issues
 - Create the next generation of champions in patient safety

Conclusions

- Medical errors are common within housestaff training programs.
- ACGME requires competency.
- By educating the next generation of physicians, Colorado can provide safer care to their patients.

Thank You !

Questions?