Learning about Patient Safety through an Interprofessional Lens

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Background

Patient safety is an emerging field for both practitioners and students of all of the Healthcare disciplines. Approximately 7.5% of hospital admissions in Canada are associated with adverse events of which 36.9% are preventable (Baker et al, 2004, p.1678). There are few resources available for institutions looking to include this topic in their curriculum. The goal of this project is to develop a reusable educational module to facilitate students' learning of Patient Safety principles in the context of a virtual patient case.

Interprofessional education

It seems natural to develop a Patient Safety educational resource using an Interprofessional framework. "Reducing adverse events and improving the quality of health care for the community can be achieved with well-prepared health care workers who have the intention to and are ready to work safely. Health care workers who are educated and trained to work together can reduce risks to patients." (National Patient Safety Education Framework, 2005, p.6). Effective Interprofessional teamwork is a recognized element of safe patient care. Deliberately designing the module as an Interprofessional experience adds a genuine experiential element to the exercise.

Objectives

By the end of the patient safety module, the student will be able to:

1. List and explain methods of reducing human error in patient care.
2. List the characteristics of a patient-centered, Interprofessional team that contribute to patient safety.
3. Identify key legal and ethical issues associated with patient safety.
4. Explain how involving patients and families/caregivers as partners in health care improves patient safety.
5. Explain the importance of communicating appropriately (e.g. in an honest and culturally sensitive fashion) with respect to issues of patient safety.
6. Assess a simulated clinical scenario and then:
   1. Identify facilitators of and obstacles to safe patient care within a complex health care system,
   2. Identify potential adverse events.
7. Demonstrate the steps in the process that should be followed when a serious adverse event or "near miss" occurrences.
8. Model the role of a member in a well-functioning patient care team faced with an issue of patient safety and be able to describe the role of other team members who represent different disciplines.

The Story

Mary Ferguson is a 75-year old woman who lives in Limestone, Ontario. She is supposed to attend her grand-daughter's dance recital, however she does not arrive at the church hall by noon as she had arranged with her daughter-in-law, Debbie. When there is no response to several phone calls, Debbie becomes alarmed. She arrives at her mother-in-law's house and hears moaning. She lets herself in and finds Mrs. Ferguson on the kitchen floor, unable to get up or reach the telephone. Debbie calls '911' and an ambulance is dispatched...

Potential educational tie-ins to case

- Acute confusion in the Geriatric patient
- Communication skills
- Community resources
- Critical thinking
- Discharge planning
- Falls prevention
- Gait assessment after injury
- Geriatric assessment
- Hip fractures
- Pelvic fractures
- Osteoporosis
- OT home safety assessment
- Polypharmacy
- Safe prescribing practices
- Team functioning
- Wound care

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Instructional design

A blended instructional design has been chosen since this strategy allows self-paced, web-based, individual learning as well as collaborative team exercises that occur both online and in class. The scheduling of synchronous face-to-face sessions can be a significant problem in the implementation of interprofessional educational programs because of the large number of students involved. The use of asynchronous online methods of communication minimizes (but does not eliminate) this problem.

The online patient story is delivered in 3 "Acts" (admission from community, hospital inpatient and discharge planning) with an optional "Prequel" outlining relevant information that predates the main story. This design allows flexible use of the module by instructors depending on the particular curricular needs of each class.

Students will work in Interprofessional groups, exploring this virtual patient's story and illness experience. The patient story will be delivered using a website that may be navigated in many different ways. It will be impossible to develop a full appreciation of the patient's issues without attention to the perspectives of the patient, her family and each of the different professionals she encounters along the way.

Each student group must accomplish a set of tasks (management decisions, incident analysis, community research) in preparation for a whole-class session emphasizing core patient safety principles. The group tasks will be designed to require communication and collaboration between students in different programs in order to model the functions of an optimal interdisciplinary team.

The module will be piloted in April 2008 with students from the Schools of Medicine and Rehabilitation Therapy (OT and PT) with particular emphasis upon the safe mobilization and discharge back to the community of our "virtual patient".

Evaluation

Following the pilot implementation of this project, students will be surveyed to determine their impressions of the learning activity, knowledge of patient safety principles and understanding of each others' roles. Focus groups will be conducted to explore the student experience in more depth in order to guide future development.

References

Baker, G.R. et al, The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. CMAJ • May 25, 2004; 170 (11).

Walton, M., National Patient Safety Education Framework, University of Sydney. 2005.