



What must a patient safety curriculum contain to be considered "foundational"?

The ABD has made it significantly easier to obtain patient safety credit, and we are encouraging a broad variety of submissions to receive patient safety credit for those conferences, institutionally-required safety sessions, courses, symposia, CME enduring materials, or other sources of patient safety education that provided a foundational education in patient safety. To qualify, foundational patient safety education must contain the following seven key content areas:

1. Epidemiology of error

Core concepts - the Epidemiology of error curriculum should prepare physicians to discuss the key definitions that underpin current patient safety efforts as well as the historical journey of the patient safety movement in the United States, in particular the release of the IOM report, To Err is Human. Rates of errors and adverse events should be discussed. The curriculum should include a discussion of the most common types of errors and adverse events, including (1) communication problems, (2) inadequate information flow, (3) human (or performance) problems, (4) patient-related issues, (5) organizational transfer of knowledge, (6) staffing patterns/work flow, (7) technical failures, (8) inadequate policies and procedures.

2. Systems thinking and the effect of the system on patient safety

Core concepts - Physicians should be able to describe the system in which they provide care - the core elements of that system include the providers, patients, support staff, clinical processes, administrative processes, technology, and information that all come together to produce the care. The curriculum should also identify the multiple layers of the healthcare system - for example, the nation, the state, the hospital, the care giving unit -- that influence the ability to improve care. The curriculum should also address how a well performing system can prevent patient harm.

3. Human factors

Core concepts - Human factors is the study of the interrelationships between humans, the tools they use, and the environment in which they work. The curriculum should discuss specific human factor interventions to improve systems and processes such as simplifying and standardizing procedures, building in redundancy into the system, improving communication within healthcare teams, and redesigning equipment to improve the human-machine interaction.

4. Safety enhancing technology

Core concepts - The curriculum should address how technology can provide an effective means for preventing and mitigating the effect of some types of errors. The curriculum should also address how technology may have unintended consequences that actually lead to more errors or additional types of errors that weren't anticipated.

5. Communication

Core concepts - The curriculum on Communication will demonstrate how communication plays a role in achieving patient safety. Several barriers exist that may affect both the physician-nurse/medical assistant and the patient-practitioner communication including safety culture and the authority gradient. Transitions of patient care are a particularly vulnerable time for patients and the curriculum should address the specific transitions that are related to the discipline, including a specific strategy for conducting the transition of care. Disclosure of adverse events should be addressed specifically and should include the strategies for accomplishing the necessary steps in effective disclosure, including: (1) telling the patient and

family what happened, (2) taking responsibility, (3) apologizing, and (4) explaining what will be done to prevent similar errors. The curriculum should include a discussion of techniques to facilitate communication between physicians and other members of the care team.

6. Culture of safety

Core concepts - The culture of safety curriculum should identify the specific elements - i.e., the beliefs, attitudes, and values about work, and risk that contribute to safety culture. The curriculum should identify the value of learning in creating and sustaining patient safety and recognize the relationship between reporting and learning. The program should make the distinction between errors resulting from deliberate unsafe acts and errors that are a result of system failures. In addition the curriculum should identify the detriments to patient safety from hierarchical gradients among members of the healthcare team.

7. Methods and tools for evaluating safety events

Core concepts - There are several common tools that are used to assess and evaluate risk as well as adverse events. One or more of the following methods should be included in the curriculum: root cause analysis, failure modes effects analysis, and probable risk assessment. In addition the tools to identify individual safety events and trends such as error reporting systems and national reporting efforts should be discussed.