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Black Ice

Five ways to get a grip on patient safety in UGME curriculum: exploring the current landscape and future positioning

Cinq façons de mieux maîtriser la sécurité des patients dans le cursus de formation médicale prédoctorale : explorer le paysage actuel et les perspectives futures

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Abstract

Efforts to increase patient safety have increased over the past 20 years. Education in patient safety has historically targeted residents, senior physicians, and healthcare professionals. Recently, patient safety has been identified as a top priority that should be instilled in the earliest stages of medical education, targeted at medical students. This Black Ice paper is intended to help readers to get a grip on how to manage barriers associated with reporting of medical errors, analysis of patient safety incidents, and integration of patient safety education curricula into existing courses and rotations.

Résumé

Les efforts visant à accroître la sécurité des patients se sont intensifiés au cours des 20 dernières années. L'éducation à la sécurité des patients a toujours ciblé les résidents, les médecins seniors et les professionnels de la santé. Récemment, la sécurité des patients a été identifiée comme une priorité absolue qui devrait être inculquée dès les premiers stades de la formation médicale, en ciblant les étudiants en médecine. Ce Terrain glissant est destiné à aider les lecteurs à comprendre comment gérer les obstacles associés au signalement des erreurs médicales, à l'analyse des incidents liés à la sécurité des patients et à l'intégration des programmes de formation sur la sécurité des patients dans les cours et les stages existants.

Introduction

Patient safety is a key facet of the healthcare system and strides have been made in the past 20 years to focus on improvement.[1] Harms that impact patient safety include physical harm, under- and over-treatment, wrong treatment, delayed or incorrect diagnosis, dehumanization, and psychological harm.[1] Patient safety spans beyond the absence of harm and requires recognition that accidents are often the result of numerous complex, contributing factors.[1] Every member of the healthcare system contributes to patient safety and this should be considered creating safer environments with the intention of reducing healthcare-associated harm.[1]

Changes in patient safety culture have been primarily targeted to residents, senior physicians and healthcare professionals.[2] In recent years, patient safety has been identified as a top priority that should be instilled in the earliest stages of medical education, at the level of Undergraduate Medical Education (UGME).[2] Despite this recognition, medical school curricula still lack sufficient patient safety education materials.[3] Adequate training in patient safety is needed to help reduce preventable harm.[4] Lack of patient safety training for medical students will likely result in the continuation of a culture of not identifying errors or identify gaps in patient safety and lack of reporting errors.

Medical students may have inaccurate perceptions of how often medical errors are made. Many students believe that competent physicians do not face medical errors.[5] This lends to the idea of "You don't know what you don't know," meaning that many medical students are unable to identify gaps in patient safety as they lack a foundational understanding of what patient safety is. Additionally, exploring the idea that "medical errors were usually caused by failures of systems, not failures of individuals," is key to changing the landscape and conversation about patient safety.[6] Implementation of a systems approach can help flag unsafe situations in the minds of medical students.

Medical errors may be reported less often than they actually occur because healthcare providers may fear repercussions such as being viewed as incompetent or incriminating others that may be involved.[6] Some clinicians also report a difficulty in admitting when they have made a mistake.[7] Additionally, consequences outside of their respective institutions, such as lawsuits, act as an additional deterrent to reporting errors.[7]

Some medical schools have identified this gap in patient safety education and proposed methods to address this.[2] A study by Ahmed et al.[8] proposed a monthly 60-minute case-based session led by junior physicians with a focus on analyzing patient safety incidents encountered in practice. This session covered key patient safety concepts, communication, and teamwork.[8] Slater et al.[9] found a 20-week interprofessional program consisting of online learning modules, multidisciplinary workshops and group discussions to be effective. Most patient safety pilot studies used a mixture of didactic and experiential teaching methods with small-group discussions, workshops and lectures.[2] Case-based learning with real-life patient safety examples identified by the participants and/or facilitators were also common.[2] Combining these education approaches with the World Health Organization patient safety curriculum guide for medical schools released in 2009 provides the needed resources to create a comprehensive curriculum surrounding patient safety for medical students.[10]

How to get a grip on patient safety in UGME curriculum

1. Develop a basic understanding of unsafe conditions in various medical settings

In collaboration with the UGME curriculum, resident physicians can lead the implementation of monthly case-based meetings by co-presenting patient safety incidents along with medical students and lead subsequent group discussion of patient safety incidents. This can lead to an open discussion on risk factors that resulted in the incident occurring, patient disclosure regarding the incident, and reflections on how it could have been prevented.

2. Utilize existing resources to understand system level safety issues in health care

After a patient safety incident, all providers should be encouraged to place focus on collecting investigative data. Continuing to utilize traditional patient safety tools such as audits or adherence to protocols should be combined with newer non-traditional approaches to understand emerging patient safety issues. Additionally, using existing resources such as CLABSI and CAUTI could aid in framing such discussions. This could include encouraging short debriefs after care encounters, utilizing fishbone cause and effect diagrams in interdisciplinary teams and regular participation in safety huddles while taking the time to discuss improvements.

3. Understand and implement root cause analysis when safety events occur

Root cause analysis refers to the process of identifying the root cause of an issue to appropriately generate solutions. In the case of patient safety, it is paramount to identify both immediate causes of a safety issue (e.g., miscommunication, equipment failure, inadequate training) and systemic causes (organizational policies, procedures, resource allocation etc.). Patient safety incident analysis assignments can be given to medical students where they can work together in groups to practice root cause analysis with unique cases. These cases can then be discussed in small group discussions lead by staff physicians or resident physicians, giving medical students the opportunity to develop their approach to root cause analysis.

4. Develop streamlined and anonymous forums to report errors and near misses that are appropriate and relevant to medical education

Medical institutions should focus on streamlining the ways in which medical errors can be reported anonymously by learners. Ensuring that the reporting process is inclusive of "near miss" errors, streamlined and anonymous is paramount in ensuring learners feel comfortable reaching out for help and receiving advice on how to move forward. Medical students can practice delivering anonymous reports through a simulated reporting system. This allows early experiences on how to report, resources available and opportunity to receive feedback to further streamline

these systems. To streamline reporting, a QR code leading to an anonymous form can be placed on the doors of clinics, patient rooms and operating room theaters.

5. Together with UGME curriculum planners incorporate a longitudinal approach to learning patient safety in the existing curriculum

Patient safety learning should be implemented in the UGME curriculum with a longitudinal learning approach, ensuring medical students' re-visit this curriculum periodically. This encourages early reflection about patient safety prior to entering the clinical environment. Additionally, as students continue to gain clinical experience, they will have a forum to bring attention to patient safety concerns they have encountered. This early acceptance of mistakes and emphasis on taking accountability will allow students to help rebuild the current culture around reporting errors.

Patient safety education is a vital component of medical education, and the five strategies outlined above offer a roadmap to equip future physicians with the knowledge and skills to prevent medical errors, promote a culture of accountability, and ensure high-quality, compassionate care for all patients.

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