Patient Safety and Quality Curriculum Objectives

Interpersonal and Communication Skills

Demonstrate the use of SBAR (Situation, Background, Assessment, Recommendation) as a tool for ensuring a common understanding of care for patients during transitions in care

Demonstrate appropriate skills and strategies for communication during difficult situations, such as disclosing a medical error

Demonstrate an understanding of the emotional impact of errors on patient or family

Provide examples of standardized tools for performing handoffs

Practice Based Learning and Improvement

Explain how cognitive strategies and human factor engineering principles can be incorporated into behaviors to prevent errors

Reflect on personal and professional experiences around medical errors

Professionalism

Identify the obligation of all physicians to participate in improving the systems that deliver care to their patients

Demonstrate professional behavior by completing all vertical curricular requirements, including course evaluations, in a timely manner.

Demonstrate professional behavior by responding to direct communication from the vertical curriculum Director or Coordinator in a timely fashion, particularly in circumstances related to academic performance.

Demonstrate professional and ethical behavior by honestly completing examinations associated with the vertical curriculum without attempting to seek advantage by unfair means, and by reporting unethical behavior of peers to clerkship administration.

Systems Based Practice

Demonstrate knowledge of the principles of patient safety and quality improvement in all aspects of health care delivery

Distinguish between adverse events and medical errors

Summarize how cognitive error can contribute to medical errors

Explain the Swiss Cheese model for system error

Define the aspects of quality in healthcare

Define Plan-Do-Study-Act (PDSA) and summarize how this quality improve tool can be used to improve systems

Explain the purpose of a “root cause analysis”

Apply knowledge of a root cause analysis to understand how systems can be improved after an adverse

Identify cognitive, team and system strategies that can be incorporated into practice to prevent errors

Describe the characteristics of high reliability organizations

Describe how quality improvement tools can be used to improve outcomes in particular diseases, such as acute myocardial infarction

Practice quality improvement principles when considering diagnostic tests, such as CT scans in patients with headache

Interpersonal collaboration

Incorporate interprofessional education to promote understanding of ideal collaborative practices