GMEC PS/QI Objectives
Approved August 4, 2017
Every SIU faculty member and resident/fellow (by the time of graduation) should be able to:

Define, discuss and meaningfully explain the following <u>Patient Safety</u> concepts:

- Culture of safety
- IOM's Six Aims of Quality Health Care*
- James Reason's Swiss cheese model of system failure.
- Pro-active Risk Assessments
    - Failure Mode Effects Analysis (used primarily by people who do daily PS work)
- Components and tools of an interprofessional patient safety event investigation (commonly called a Root Cause Analysis (RCA) or systematic analysis).
    - Review by inter professional team
    - Detailed analysis of systems and processes
    - Identification of potential systems changes
    - Implementation of an action plan.
    - Follow-up evaluation of the actions
    - Fishbone diagram (or Ishikawa diagram)
    - Learning from Defects tool
- The full range of reportable events
    - Events with harm.
    - Near Misses (potential for harm but did not reach the patient)
    - Unsafe conditions
    - Unexpected deterioration
    - Complications
- Disclosure of adverse events to patients and families
- The difference between a patient safety investigation and peer review

Define, discuss and meaningfully explain the following <u>Quality/Performance Improvement</u> methodologies, processes and tools:

- Lean*
- Six Sigma*
- PDSA cycle*
- TeamSTEPPS**
- Variation

Define, meaningfully discuss and demonstrate (where applicable) the following concepts:

- Health care disparities, including
    - Social determinants of health
    - Cultural competence or humility
    - The role of implicit bias

For any given clinical setting, demonstrate a working knowledge of:

- The most common patient safety events in that environment
- How to report adverse events and near misses
- Where to seek assistance when a patient safety event occurs.

- Patient Safety goals and tools (or how to access)
- How to access and utilize quality metrics and benchmarks related to that patient population
- Priorities in addressing health care disparities common to that clinical population (or how to access)
- Strategies to mitigate health care literacy limitations such as teachback.

Consistently demonstrate:

- Reporting of adverse events/near misses/close calls
- Patient Handoffs that include:
    - Summary statement of current patient circumstances and context
    - Active issues, including current and anticipated problems
    - If - then contingency planning
    - Follow-up recommendations for any tests, procedures or treatments.
    - Active listening and interactive questioning.
    - Readback where appropriate

Experience and meaningfully participate in:

- Inter-professional patient safety event investigations (mock or real)
- One or more quality improvement projects, including
    - Assessment and follow-up of interventions
    - Ability to articulate and explain the methods and approaches used

*These concepts are addressed in White Belt training program.
**Team Strategies and Tools to Enhance Performance and Patient Safety are available in TeamSTEPPS training.