

Learning Objective	IHI Module	SIU PS/QI Recorded Session	GME Live Session/Activity	Hospital PS/QI or MHQA Staff	SIU HealthCare Staff	MMC Executive White Belt Program	SJH Team STEPPS	SOAR
Patient Safety Concepts								
<p>Culture of Safety</p> <p>The Center for Disease Control has defined a culture of safety as the shared commitment of management and employees to ensure the safety of the work environment. The safety of patients is paramount. A culture of safety acknowledges the inevitability of error, and proactively seeks to identify latent threats. Characteristics of such a culture include: Environment where individuals are confident that they can report errors or close calls ("near misses") without fear of retribution; Collaboration across the ranks to seek solutions to system vulnerabilities; Demonstrated willingness to direct resources to address safety concern.</p> <p>An organization with a culture of safety encourages acknowledgment of error and actively attributes such primarily to process/system failures. Lessons learned from analysis of errors are shared as the best known methods to mitigate and prevent future errors.</p>	PS104 and PS202	Sattovia, 10.2013 Session						
Glossary and Definitions of Frequently Used Terms						X		
IOM's Six Aims of Quality Health Care: HealthCare must be SAFE, EFFECTIVE, PATIENT-CENTERED, TIMELY, EFFICIENT and EQUITABLE.	QI101							

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James Reason's Swiss cheese model of system failure	PS102	Sattovia, 8.2014 Session						
Pro-Active Assessment (FMEA) Used primarily by people who do daily PS work (see Glossary)				X				
Components and Tools of interprofessional patient safety investigations Sample Fishbone Diagram Sample Learn from Defects Tool	PS201	Sattovia, 10.2015 Session	Mock RCA	X				
Difference between Patient Safety Investigation and Peer Review			MedicoLegal Session (Part 1)	X				
Disclosure of Adverse Events to Families	PS105	Sattovia, 10.2015 Session	Patient Simulation					
Full Range of Reportable Events			Mock RCA	X				
Reporting of Adverse Events/Near Misses/Close Calls	PS202		Mock RCA	X				
Informed Consent			MedicoLegal Session (Part 1) and Patient Simulation					
Most Common PS events in SIU Clinical Settings		Sanfey, 2.2014 Session		X	X			
Where to seek assistance when a PS event occurs			New Resident Orientation	X				
Patient Safety Goals and Tools (or how to access)			New Resident Orientation	X				

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Effective Patient Handoffs	PS104	Sanfey, 1.2015 Session	New Resident Orientation					
Quality/Performance Improvement								
Lean	QI301					X		
Six Sigma	QI301					X		
PDSA cycle	QI103	Sattovia, 1.2014 Session				X		
TeamSTEPPS (Communication)	PS104	Sanfey, 1.2015 Session					X	
Variation	QI104	Sattovia, 3.2015 Session				X		
Meaningful Participation in one or more QI Projects	QI301		QI Project Competition			X		X
Health Care Disparities								
Social Determinants, Cultural Competence, Implicit Bias CDC Social Determinants of Health: Know What affects Health CDC 500 Cities: Local Data for Better Health County Health Rankings and Roadmaps: Building a Culture of Health, County by County 2017 Illinois Health Rankings, Sangamon County Office of Disease Prevention and Health Promotion: Healthy People 2020	TA101		New Resident Orientation		X			

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What are Social Determinants of Health?								
How to Access & Utilize Quality Metrics and Benchmarks Related to Patient Population	QI104			X	X			
Priorities in Addressing Health Care Disparities Common to that Clinical Population	TA102	Lausen, 4.2014 Session	New Resident Orientation		X			
Strategies to Mitigate Health Care Literacy Limitations such as Teachback Agency for HealthCare Research and Quality Patient Safety Network - Patient Safety Primer - Health Literacy Agency for HealthCare Research and Quality Patient Safety Network - Health Literacy Universal Precautions Toolkit, 2nd Edition: Use the Teach Back Method: Tool#5 Always Use the TeachBack! Training toolkit	TA103		New Resident Orientation		X			