

Lives in Our Hands:
Overcoming Barriers
to Patient Safety

Facilitator Guide

Instructions for Discussion

The length of the video is either 25:45 minutes or 20:45 minutes. The longer version has documentation examples from the medical record. Ideally at least an hour should be allowed for viewing and discussing the video with the audience.

Because the content of the video can be emotionally upsetting to those viewing it, it may be helpful to ask the audience to reflect silently for a few minutes on the issues that they found most disturbing in the video before asking them to come together and discuss as a group.

Below are some example questions for the audience, based on the culture of your institution feel free to add or delete questions as appropriate.

1. Could the events of this video happen in your unit today?
2. How do we tap the value of patient family input and concerns and build that into the patient's care?
3. What is the patient's and family's role in the patient's care?
What do you do to ensure that they understand the roles they occupy?
4. Formulate a list of steps this intern should have taken in your service and when.
How do you communicate those to your trainees?
5. What would you advise a nurse do when he or she does not get a response after repeated calls?
Identify strategies for escalating when the patient's health demands it.
6. How do you think the nurse might have been more effective in communicating her concern to the medical team?
7. Whose responsibility is it to create and grow a safe culture?
8. What behaviors do clinicians* need to exhibit to show they are committed to a culture of safety:
Attending's, residents, interns, nurses, respiratory therapists, pharmacists, assistive personnel*?

**Educational Objectives and Discussion Questions for:
“Lives in Our Hands: Overcoming Barriers to Patient Safety”
(with clinical details)**

1. Placing the patient at the center of all we do as health care providers is more difficult than it seems. Identify all the aspects of a health care environment that compete with the goal of creating a patient-centric culture, including aspects of human nature, financial and environmental incentives and disincentives.

2. Feeling both safe AND a personal duty to ask for help when the patient’s needs demand it are signs of a healthy culture. Describe other attributes of a culture that creates these expectations and similarly, recognize the barriers that prevent development of a healthy culture.

3. Identify how the quality of communication between all members of the healthcare team impacts patient safety.

4. Health care is clearly a team activity. Discuss strategies for developing integration and cohesiveness within the care giving team.

5. Patients and families are the central focus of a patient centered health care experience. What strategies are useful to elicit their concerns, useful observations and participation in their care?

6. How does personal accountability at every level of the patient care team impact patient safety?

7. The teaching responsibility means more than simply delegating to subordinates and forcing them to learn on the job alone. Discuss the ethical demands that are unique to an academic medical environment and identify what meaningful supervision and training look like.

8. Examine reasonable expectations from the patient and family perspective. What are they ethically and practically entitled to when an unanticipated outcome occurs? What are the barriers?

Lives in Our Hands

Annotated Bibliography

McMyler E, Ross P, Saran K, Urteaga-Fuentes A, Anderson S, Boothman R, Lypson M. Mainstreaming Risk Management Education Into New Resident and Fellow Orientation.

Journal of Graduate Medical Education. 2011 Vol 3(3)395-399.

This article discussed the introduction of a new method using a video and a facilitated discussion to introduce the topic of patient safety to new house officers and new fellows. The findings supported that the new method was an effective way to highlight the importance of communication and supervision related to patient safety.

Ross P, McMyler E, Anderson S, Saran K, Urteaga-Fuentes A, Boothman R, Lypson M. Trainees' Perceptions of Patient Safety Practices: Recounting Failures of Supervision.

The Joint Commission Journal on Quality and Patient Safety. 2011 Vol 37(2) 88-95.

Authors analyzed an open ended questionnaire asking for descriptions of situations in which they witnessed a failure of supervision and their corresponding responses. The . responses of 334 newly hired interns, residents and fellows identified two primary sources of failures of supervision: supervisors' failure to respond to trainees seeking of guidance or clinical support and trainees' failure to seek such support. Improved supervision and communication within the medical hierarchy should not only create more productive learning environments but also improve patient safety.

Raouf E. Disclosure of Errors in Pathology and Laboratory Medicine.

American Journal of Clinical Pathology. 2011: 666-667.

The author brings attention to the differences in disclosing errors to patients based on individual case, though he believes there should be standardization. It raises several questions.

Baldwin Jr D, Daugherty S, Ryan . How Residents View Their Clinical Supervision: A Reanalysis of Classic National Survey Data.

Journal of Graduate Medical Education. 2010. Vol 2(1)37-45.

Authors reanalyzed data collected by surveying second and third year residents, according to service, about their views on clinical supervision. Analysis found that there was a great variety on clinical supervision depending on specialty and that the less adequate clinical supervision a resident experienced the more negative features of training were reported, such as medical errors, sleep deprivation or working while impaired. It was concluded that lack of adequate clinical supervision of residents is not only detrimental to resident learning but also to patient safety.

Kashner T, Byrne J, Chang B, Henley S, Golden R, Aron D, Cannon G, Gilman C, Holland G, Kaminetzky C, Keitz S, Muchmore E, Kashner T, and Wicker A, . Measuring Progressive Independence With Resident Supervision Index: Theoretical Approach.

Journal of Graduate Medical Education. 2010. Vol 2(1) 8-16.

This article aims at providing an index of proper resident supervision that adequately progresses residents to gain independence without exceeding their level of education, potentially causing harm to patients. Authors conclude that in order to obtain an accurate index, an explicit theoretical framework is needed.

Behal R, Finn J. Understanding and Improving Inpatient Mortality in Academic Medical Centers.

Academic Medicine. 2009 Vol. 84(12) 1657-1662.

This study, involving sixteen academic medical centers, found that to reduce the preventable mortality index physician leadership, such as department chairs, need to be engaged in a dedicated method of change. This conclusion was found by identifying the key factors that contributed to preventable mortality; this was done by consultations of medical centers including interviews with medical staff, hospital leadership, reviews of medical records and on-site evaluation of systems and processes. After the initial consultation, a follow-up evaluation was done five years after to measure improvement in the preventable mortality index. Those with higher physician leadership had correlating higher index of improvement.

Jasti H, Sheth H, Verrico M, Perera S, Bump G, Simak D, Buranosky R, Handler S . Assessing Patient Safety Culture of Internal medicine House Staff in an Academic Teaching Hospital.

Journal of Graduate Medical Education. 2009. Vol 1(1)1-12.

This study aimed to determine importance of patient safety culture (PSC) to house staff compared to postgraduate year trainees. Authors administered the Hospital Survey on Patient Safety Culture which has 12 PSC dimensions. Based on their results a need to establish a PSC benchmark and identifying targets to improve PSC was found.

Keller D, Bell C, Dottl, S. An Effective Curriculum for Teaching Third-Year Medical Students about Medical Errors and Disclosure.

Wisconsin Medical Journal 2009. Vol 108(1)28-29/80.

This study outlines an educational program used to educating third-year medical students on disclosing medical errors. It describes the four hour session in which patient relations, hospital administrators and legal address standard of care and how to handle when it is not met. The lectures and student break-out sessions with role play are rated highly satisfactory by participants.

Leape L, Berwick D, Clancy C, Conway J, Gluck P, Guest J, Lawrence D, Morath J, O'Learty D, O'Neill P, Pinakiewicz D, Isaac T. Transforming healthcare: a safety imperative.

Quality and Safety in Health Care. 2009; Vol. 18:424-428.

Although severe failures in patient safety were identified ten years ago in an alarming report by the Institute of Medicine, progress has been hindered by persistence to follow a medical hierarchy structure in academic medicine. This article outlines and illustrates implications of Lucian Leape Institute's five concepts (transparency, care integration, patient/costumer engagement, restoration of joy and meaning in work and medical education reform) as fundamental to achieving significant improvement to healthcare system safety.

Mayer D, Klamen D, Gunderson A, Barach P. "Designing a Patient Safety Undergraduate Medical Curriculum: The Telluride Interdisciplinary Roundtable Experience."

Teaching and Learning in Medicine. 2009. Vol 21(1) 52-58

This article outlines the process of developing a patient safety curriculum. This curriculum was built by a panel of experts over two years, in which a list of general curricular principles and 11 specific elements were outlined. The curriculum was then fine-tuned over several years and has been piloted in several medical schools. It continues to be refined as new barriers and challenges arise.

Philibert, I. "Use of Strategies from High-Reliability Organisations to the patient hand-off by resident physician: practical implications."

Quality and Safety in Health Care 2009. Vol 18(4)261-266.

This study brought light to problems on more frequent hand-offs caused by stricter limitation on resident hours. More hand-offs were found to contribute to a higher incidence of adverse events. Along with a greater number of hand-offs, level of clinical skill also attributed to adverse events. Researchers concluded that although third parties, particularly nursing, trapped many hand-off errors there is a need for more education and supervision for junior residents to prevent errors in hand-offs.

Sanders J, Bax N, Mayer D, Wass V, Vickers R. Education undergraduate medical students about patient safety: Priority areas for curriculum development.

Medical Teacher. 2007. Vol. 29:60-61.

This article highlights the importance of educating undergraduate medical students on patient safety. It is important to incorporate patient safety into undergraduate curriculum so that future physicians can develop skills, awareness and are able to take responsibility when patient safety issues arise. Several recommendations are included to develop a strong curriculum.

Singh H, Thomas E, Peresen L, Studdert D . Medical Errors Involving Trainees- A Study of Closed Malpractice Claims From 5 Insurers.

Archives of Internal Medicine 2007. Vol 167(19)2030-2036.

Authors did a study of 240 claims involving trainees over roughly 20 years. Their findings identified that in the majority of the cases the trainees errors could be attributed to teamwork problems, such as lack of supervision and hand-off issues, and lack of technical competence or knowledge, such as diagnostic decision making and monitoring the patient or situation. The conclusion was made that graduate medical reform should focus on strengthening the identified issues.

Leape L. Full Disclosure and Apology- An Idea Whose Time has Come.

The Physician Executive. March-April 2006:16-18.

Dr. Lucian Leap from Harvard University points out both the ethical and therapeutic components of disclosing and apologizing when an error occurs. The author states that disclosing is an essential part of the healing process and also the importance of sincere apologies and appropriate settlements, while recognizing barriers and offering suggestions to move ahead.

Nembarid I, Edmondson A. Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams.

J. Organiz. Behav. 2006. Vol 27: 941-966

This paper suggest that leader inclusiveness, the behaviors exhibited by leaders that encourage others' contributions, improves psychological safety. These findings are

supported by data collected in 23 neonatal intensive care units involved in quality improvement projects.

Shojania G, Fletcher K, Saint S. Graduate Medical Education and Patient Safety: A Busy - and Occasional Hazardous- Intersection.

Annals of Internal Medicine. 2006; Vol. 145:592-598.

This article features a case study of an adverse event involving an elderly patient.

The adverse outcome highlights several downfalls resulting from lack of proper supervision, improper hand-offs, not asking for help and miscommunication. The case study clearly shows consequences of attending physicians failing to provide adequate supervision further causing their trainees to provide inadequate supervision perpetuating a vicious cycle that endangers patients.

Weingart S, Pagovich O, Sands D, Li J, Aronson M, Davis R, Bates DW, Phillips R. What Can Hospitalized Patients Tell Us About Adverse Events.

Journal of Internal Med, 2005. Vol 20:830-836.

In this study, researchers found that inpatients are able to identify medical errors or near misses, many which are not captured in hospital incident reporting systems.

They also found that engaging hospitalized patients to participate in their care can enhance patient safety. Researchers reached this conclusion by surveying 228 adult patients in a Boston teaching hospital. Participants were interviewed both during their hospitalization and then 10 days after discharge about “problems, mistakes, and injuries” that occurred.

University of Michigan Health System
Patient Safety video Project Manager
Office of Clinical Safety
300 North Ingalls, Room 8A06
Ann Arbor, Michigan 48109-5478
734/763-5456
emcmlyer@umich.edu