AHMC801

Safety and Quality in Hospital Care

SM9 Day 2015

School of Advanced Medicine

Contents

Disclaimer

Macquarie University has taken all reasonable measures to ensure the information in this publication is accurate and up-to-date. However, the information may change or become out-dated as a result of change in University policies, procedures or rules. The University reserves the right to make changes to any information in this publication without notice. Users of this publication are advised to check the website version of this publication [or the relevant faculty or department] before acting on any information in this publication.

General Information

Unit convenor and teaching staff
Unit Convenor
John Cartmill
john.cartmill@mq.edu.au

Credit points
4

Prerequisites
Admission to DAdvSurg or DAdvMed or MAdvSurg or MAdvMed or MSurg or MMed or MMedPrac or DClinPrac or GradDipSpSurg or GradDipSpMed or GradCertClinLship or MLabQAMgt

Corequisites

Co-badged status

Unit description
Safety and quality are vitally important and ongoing aspects of hospital care. This unit critically examines decision making and error in everyday life and progresses these concepts by focusing on medical errors, how to respond to error, how to discuss error with patients and colleagues, and how to prevent errors from happening again. Discussions also include examining how medical error is reported in the media and potential political and legal responses to error.

Important Academic Dates

Information about important academic dates including deadlines for withdrawing from units are available at https://www.mq.edu.au/study/calendar-of-dates

Learning Outcomes

On successful completion of this unit, you will be able to:

Understand the scope, nature and causes of the most common safety problems

Understand human factors in theory and practice

Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work

Understand what constitutes a safety culture and how to foster change

Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives

Demonstrate capacity to learn from error, including the RCA Process
Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure
Demonstrate an understanding of personal ergonomics and determinants of human performance
Demonstrate an awareness of the impact of the media and the legal system on human error

Assessment Tasks

Name	Weighting	Due
Quiz - to get you thinking	40%	Every tutorial
Short written assessment	10%	Date TBA via iLearn
Presentation	25%	Date TBA via iLearn
QI Project	25%	Date TBA via iLearn

Quiz - to get you thinking

Due: **Every tutorial**
Weighting: **40%**

A series of readings have been listed for this unit. This assessment requires the completion of these set readings and their associated quiz questions (found in iLearn) prior to each of the tutorials. This assessment is continuous through the semester and requires the online completion of quiz questions prior to the tutorials. This assessment also includes participation in discussions in the tutorials.

On successful completion you will be able to:

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Understand what constitutes a safety culture and how to foster change
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate capacity to learn from error, including the RCA Process
- Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure

- Demonstrate an understanding of personal ergonomics and determinants of human performance
- Demonstrate an awareness of the impact of the media and the legal system on human error

Short written assessment

Due: **Date TBA via iLearn**
Weighting: **10%**

This is to be a short (200 words) description of a personal experience of a work-based error (de-identified) or other safety and quality activity (such as root cause analysis or open disclosure). Feel free to report the facts (de identified), ensure you include your thoughts and feelings on the event as well as its repercussions. The intention is to cement your commitment to the course.

This could form the basis of your end of term presentation or written assignment - but doesn't have to.

On successful completion you will be able to:

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand what constitutes a safety culture and how to foster change
- Demonstrate an understanding of personal ergonomics and determinants of human performance

Presentation

Due: **Date TBA via iLearn**
Weighting: **25%**

For this assessment, you are to choose (and check with John Cartmill) a safety and quality topic and prepare a 10 minute education session (inclusive of five minutes of questions/discussion). You should prepare a PowerPoint presentation with a maximum of four slides. This presentation is to form the basis of a talk that could be given as a “Grand Rounds” presentation and is limited to five minutes here only because you will be speaking to an already well informed group.

You should choose a topic that fascinates you. These topics can be discussed at the first tutorial.

On successful completion you will be able to:

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice

- Understand what constitutes a safety culture and how to foster change
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure
- Demonstrate an awareness of the impact of the media and the legal system on human error

QI Project

Due: **Date TBA via iLearn**
Weighting: **25%**

For this assessment, you are to design a proposal for a quality improvement project for a potential or actual system-based error that you have noticed in your workplace (former or current) or even in your home. This error can be "trivial" (for example, patients' dentures that continuously go missing). You will then write a report regarding the proposal. This 800 word report should include:

- a description of the error and how it was identified
- a description of the investigation into the cause of the error (mini Root Cause Analysis), with reference to relevant literature
- a description of the possible solutions to prevent further error, and
- a quality improvement plan (relating to the chosen solution) detailing what changes were made and how and also how these changes might be evaluated and maintained.

The report should also demonstrate an understanding of the concepts that you have been developing though the course.

On successful completion you will be able to:

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand what constitutes a safety culture and how to foster change
- Demonstrate an understanding of personal ergonomics and determinants of human performance

Delivery and Resources

This Unit has an online presence in iLearn. You will need access to the internet and a computer, as well as the ability to participate in online forums and communicate by email.

A list of required and recommended readings is available in iLearn. These are available through

the Library.

Unit Schedule

There will be six tutorials/group discussions in the semester. The last of these will be for class presentations.

Date and Time	Topics
This unit is for SM9 deliver. Dates will become available via iLearn.	*To err is human* • Learning Styles • Human Factors • Simple error • Performance shaping factors
	To err is human • Ergonomics • Optimising performance • Happiness • Decision-making • Technical and non-technical skills
	• Teams
	• Realisational Systems • Engineered Systems
	To repent is divine • Error • Catastrophe theory • Hindsight bias and attribution effect
	To repent is devine • Debriefing and disclosure • Root cause analysis (and the "logic bubble") • Feedback
	To persevere is diabolical • Management • Audit and process improvement • Regulation • Media • Politics • Law

	• Class presentations • Summary discussion

Scholars are expected to attend and participate in the tutorials and workshop offered in the unit. Participation includes actively contributing to group discussions and engaging in simulation activities.

Policies and Procedures

Macquarie University policies and procedures are accessible from Policy Central. Students should be aware of the following policies in particular with regard to Learning and Teaching:

Academic Honesty Policy http://mq.edu.au/policy/docs/academic_honesty/policy.html

Assessment Policy http://mq.edu.au/policy/docs/assessment/policy.html

Grading Policy http://mq.edu.au/policy/docs/grading/policy.html

Grade Appeal Policy http://mq.edu.au/policy/docs/gradeappeal/policy.html

Grievance Management Policy http://mq.edu.au/policy/docs/grievance_management/policy.html

Disruption to Studies Policy http://www.mq.edu.au/policy/docs/disruption_studies/policy.html *The Disruption to Studies Policy is effective from March 3 2014 and replaces the Special Consideration Policy.*

In addition, a number of other policies can be found in the Learning and Teaching Category of Policy Central.

Student Code of Conduct

Macquarie University students have a responsibility to be familiar with the Student Code of Conduct: https://students.mq.edu.au/support/student_conduct/

Results

Results shown in *iLearn*, or released directly by your Unit Convenor, are not confirmed as they are subject to final approval by the University. Once approved, final results will be sent to your student email address and will be made available in eStudent. For more information visit ask.mq.edu.au.

Student Support

Macquarie University provides a range of support services for students. For details, visit http://students.mq.edu.au/support/

Learning Skills

Learning Skills (mq.edu.au/learningskills) provides academic writing resources and study strategies to improve your marks and take control of your study.

- Workshops

- StudyWise
- Academic Integrity Module for Students
- Ask a Learning Adviser

Student Services and Support

Students with a disability are encouraged to contact the Disability Service who can provide appropriate help with any issues that arise during their studies.

Student Enquiries

For all student enquiries, visit Student Connect at ask.mq.edu.au

IT Help

For help with University computer systems and technology, visit http://informatics.mq.edu.au/help/.

When using the University's IT, you must adhere to the Acceptable Use Policy. The policy applies to all who connect to the MQ network including students.

Graduate Capabilities

PG - Capable of Professional and Personal Judgment and Initiative

Our postgraduates will demonstrate a high standard of discernment and common sense in their professional and personal judgment. They will have the ability to make informed choices and decisions that reflect both the nature of their professional work and their personal perspectives.

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Understand what constitutes a safety culture and how to foster change
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure
- Demonstrate an understanding of personal ergonomics and determinants of human performance

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

PG - Discipline Knowledge and Skills

Our postgraduates will be able to demonstrate a significantly enhanced depth and breadth of knowledge, scholarly understanding, and specific subject content knowledge in their chosen fields.

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Understand what constitutes a safety culture and how to foster change
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate an understanding of personal ergonomics and determinants of human performance
- Demonstrate an awareness of the impact of the media and the legal system on human error

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

PG - Critical, Analytical and Integrative Thinking

Our postgraduates will be capable of utilising and reflecting on prior knowledge and experience, of applying higher level critical thinking skills, and of integrating and synthesising learning and knowledge from a range of sources and environments. A characteristic of this form of thinking is the generation of new, professionally oriented knowledge through personal or group-based critique of practice and theory.

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate capacity to learn from error, including the RCA Process

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

PG - Research and Problem Solving Capability

Our postgraduates will be capable of systematic enquiry; able to use research skills to create new knowledge that can be applied to real world issues, or contribute to a field of study or practice to enhance society. They will be capable of creative questioning, problem finding and problem solving.

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate capacity to learn from error, including the RCA Process

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

PG - Effective Communication

Our postgraduates will be able to communicate effectively and convey their views to different social, cultural, and professional audiences. They will be able to use a variety of technologically supported media to communicate with empathy using a range of written, spoken or visual formats.

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Understand what constitutes a safety culture and how to foster change
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate capacity to learn from error, including the RCA Process
- Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure
- Demonstrate an understanding of personal ergonomics and determinants of human performance
- Demonstrate an awareness of the impact of the media and the legal system on human error

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

PG - Engaged and Responsible, Active and Ethical Citizens

Our postgraduates will be ethically aware and capable of confident transformative action in relation to their professional responsibilities and the wider community. They will have a sense of connectedness with others and country and have a sense of mutual obligation. They will be able to appreciate the impact of their professional roles for social justice and inclusion related to national and global issues

This graduate capability is supported by:

Learning outcomes

- Understand the scope, nature and causes of the most common safety problems
- Understand human factors in theory and practice
- Understand the nature and elements of well functioning teams in patient care and demonstrate techniques to make a team work
- Demonstrate capacity to lead, coordinate and participate in quality improvement initiatives
- Demonstrate capacity to learn from error, including the RCA Process
- Understand the purpose and importance of and demonstrate competence in talking about error with clinicians, managers, patients and families, including open disclosure

Assessment tasks

- Quiz - to get you thinking
- Short written assessment
- Presentation
- QI Project

Learning and Teaching Strategy

This unit employs a blended approach to learning with group discussions, readings with quiz questions, and written assessment tasks. Students are expected to actively participate in group discussion by preparing with the appropriate readings and quizzes. There are three broad themes in this unit of study.

To Err is Human

This module will cover a number of topics concerning human error and safety: how errors occur, human factors, and ways of avoiding or managing error. Broader perspectives of system error and error theory will be introduced, including:

· How we learn

· How we decide

· How we act, react, and interact (work together)

· Understanding error

o How individuals err

o How teams err

o How systems err

To Repent is Divine

· Responding to error

This module addresses responses to error. Protective mechanisms such as denial and projection are acknowledged and developed into an approach for learning from error (incident reporting and root cause analysis).

· Talking about error

In this module, we will focus on how we explain and talk about error. This includes the concepts of debriefing, “difficult conversations” with colleagues, open disclosure, complaints processes, and speaking up about error. We will also discuss how best to provide leadership and support after a serious error.

To Persevere is Diabolical

· Preventing error

This module covers the role of audit and quality improvement leadership, teamwork and culture as well as an overview of several error prevention systems.

· Media, politics and the law

In this module, we will investigate the relationships between medical error, media, politics and the law. This includes consideration of high profile cases both nationally and internationally as well as how these are reported in the media and how they are fed into legislative change.