Foundations in

Patient Safety for Health Professionals

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This book is dedicated to

Mike,
Ryan, Christine, and Jenee
and Sandy

Pat,
Becky, Juande, and Lucia,
Katie and Neel

May the lessons learned by those who read this book help to make your health care safer.
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The 1999 release of the Institute of Medicine (IOM) report, *To Err Is Human*, was a wake-up call for American health professionals and institutions. It created great concern and a heightened awareness that all is not well in American health care, and it sparked a national effort to address the human and system flaws that result in medical errors. The subsequent release of the second report of the IOM Committee on Quality of Health Care in America, *Crossing the Quality Chasm*, laid out strategies for addressing and reducing errors, including system and institutional design change, development, and application of evidence to the study of errors, aligning payment with quality, and enhancing the education of health professionals.

In 2002, the IOM convened a Health Professions Education Summit that produced a third report, *Health Professions Education: A Bridge to Quality*. This report defined five core competencies of health professionals necessary to improve quality, reduce errors, and assure patient safety. Competent health professionals should provide patient-centered care, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement, and utilize informatics.

In 2003, in response to the clear need to address the development of students’ competence to work in interdisciplinary teams, Creighton University established an Office of Interprofessional Education, of which I was named director. Several interprofessional teams were assembled to plan and implement educational experiences to offer students of Creighton’s health professions schools and programs. One of the interprofessional teams, comprising expertise in law, medicine, nursing, pharmacy, physical therapy, occupational therapy, social work, systems design, and decision sciences, embarked on the development of an interprofessional course in Patient Safety offered to students in several colleges and schools within the university. It is that course and the experiences of its faculty who are teaching that have given rise to this book.

As pioneers, course faculty quickly found that there was no extant text available that met the needs of their students. In consequence, they embarked on distilling...
the essence of the course to develop the present comprehensive text and approach
to teaching patient safety to a group of students drawn from a variety of profes-
sions. This is an interprofessional faculty teaching an interprofessional student
body.

This text presents the background and need for safety improvement, why er-
rors occur, principles of patient safety assurance, quality and safety improvement,
the appropriate and constructive use of evidence, the importance of systems de-
sign, and organizational structure and culture. It also addresses questions of safety
from patients’ and professionals’ perspectives and, very importantly, the respon-
sibilities of professionals, employers, and organizations when errors occur, when
patient safety is compromised, or when patients are injured.

The work will be of great value to similar interprofessional teams teaching stu-
dents drawn from a variety of professional backgrounds, including not only the
health professions but also management, law, systems design, decision sciences,
and information technology.

Richard L. O’Brien

Richard L. O’Brien, MD, FACP

Richard O’Brien is University Professor and a member of the Center for
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2002 Institute of Medicine Health Professions Education Summit and in 2003
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Creighton, a position he held until 2006. During his tenure in this office he
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cation activities for students of business, law, dentistry, medicine, nursing,
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dean of the School of Medicine at Creighton from 1982 to 1992 and vice pres-
ident for Health Sciences from 1984 to 1999. He and two colleagues have
recently published a book, Cultural Proficiency in Addressing Health Disparities
(also published by Jones and Bartlett). He is currently engaged in studying and
teaching the ethics of health policy formation, human subject research, and the
reduction of health disparities.
REFERENCES


Acknowledgments

Why would 15 faculty members from across a university campus, with no particular reason to work together, establish solidarity in our commitment to teaching students about the sciences of patient safety?

There is only one reason. Each of us has a personal story. The story is one of harm and injury through errors, mishaps, and mistakes. For some of us the story describes the pain, suffering, or losses of our own loved ones. For others, the story illustrates the pain, suffering, or losses incurred by others we tried to care for through our own professional experiences.

And while each story is unique to the persons or places involved, all stories share a common and powerful feature— isolation. Each of us had not discussed our own personal story with others to any great extent. Where would one go to do that? Where is the support system or vehicle for communication with each other about this? Let’s face it; we had an unusual and rare experience, didn’t we? What happened couldn’t possibly be frequently encountered by others, we rationalized.

But our experiences are frequently encountered by others. The overwhelming body of evidence has repetitively shown us this truth. And even more astounding is that we know that much of this harm and injury is avoidable. Avoidable if we each take responsibility for being competent at and applying safety principles to patient care delivery.

We are indebted to those who have brought this most important area of care and concern into the visible forefront of our social priorities—the scientists, clinicians, and advocates for patient safety. Most of all, we are grateful to the individuals and families who have experienced harm, but are willing to share their stories with the hope of making a difference in the lives of others.
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James D. Bramble is an associate professor in the School of Pharmacy and Health Professions and the Director of the Health Services Administration Certificate Program at Creighton University. Dr. Bramble teaches courses on research methodology and biostatistics, as well as healthcare management and patient safety. His research focuses on patient safety, health information technology, and resource utilization in healthcare organizations. He has been involved in many funded grant projects, published in both books and health science research journals, had book reviews accepted for publication, been an adjunct journal reviewer, and has presented at many conferences and meetings. Dr. Bramble also has a secondary appointment in the School of Medicine’s Department of Anesthesiology and has held a Creighton Center for Health Services Research and Patient Safety faculty membership since 2004. He participates in the interprofessional education course Foundations in Patient Safety. Dr. Bramble is a Patient Safety Expert Panel Reviewer for the Creighton Center for Health Services Research and Patient Safety, Patient Safety Organization.
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Janet Graves is the chair of the Traditional Curriculum at Creighton University School of Nursing. She taught Nursing of Children for several years and currently teaches Informatics in Health Care. Her interest in patient safety developed when providing nursing care for children. Her current work in informatics has led to interest in information technologies that have the potential to improve patient safety. Dr. Graves is also the director of eLearning in the School of Nursing. Her research interests include uses of mobile information devices at the point of care and effective methods of online teaching and learning.

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Barbara Harris is the field practicum coordinator for the Department of Social Work at Creighton University. She teaches practice courses in social work. Her community involvement is primarily focused on family violence and child poverty. She served on several community boards to identify the intraprofessional approaches to addressing social welfare needs. As director of the Center for the Study of Children's Issues and as a founding member of the Domestic Violence Coordinating Council, she advanced this interprofessional framework. She served on the interprofessional task force on patient safety curriculum development for Creighton University. She, along with the coauthors of this book, developed the interdisciplinary patient safety course in 2005.

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Pat Hoidal is the director of Performance Improvement and Risk Management at Saint Elizabeth Regional Medical Center in Lincoln, Nebraska. As the patient safety officer, she is responsible for facilitating the use of evidence-based practice and process improvement tools. She currently leads initiatives aimed at improving
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Dr. McQuillan was an associate professor and chair, Department of Anesthesiology at the Creighton University Medical Center and Creighton University School of Medicine. Dr. McQuillan completed his Doctor of Medicine at Creighton University and his anesthesiology residency with a fellowship in pain medicine at the University of Missouri–Kansas City/St. Luke’s Hospital. He provided strong interprofessional leadership to bring crew resource management techniques, including the Agency for Healthcare Research and Quality TeamSTEPPS program, into the operating room and presurgical and postsurgical care models. He conducted his work at Creighton University Medical Center and nationally, leading interdisciplinary education and research on the implementation and evaluation of the effectiveness of this approach to patient safety. He continuously studied human factors science with a goal of improving patient safety, motivated to care for those patients who received his services in the operating room. Dr. McQuillan was a founding faculty member of the campus-wide interdisciplinary Foundations in
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