Professionalism, Patient Safety & Quality Improvement Curriculum

Prior to graduation, **each trainee is required to:**

1) Complete specific AMA Introduction to Practice of Medicine (IPM) and IHI on-line modules listed below to enhance base-line knowledge in Professionalism, Quality Improvement and Patient Safety;

2) Complete at least one Quality Improvement or Safety Improvement Project and present findings to at least one of the Annual Quality and Safety Summits ; and,

3) Write up and submit at least one Quality or Safety Improvement Project results to a peer-reviewed journal or magazine or submit at least one Quality or Safety Improvement Project for presentation to a regional or national meeting.

Core Competency	Topic	AMA IPM Module Objectives
Interpersonal & Communication Skills	**Residents As Teacher**	1. Orient a learner to you (the resident), the setting and the patient. 2. Describe the steps in the One-Minute Preceptor. 3. Identify the characteristics of formative feedback.
Interpersonal & Communication Skills	**Patient Handoffs**	1. Define the term "patient handoff". 2. Discuss the importance of patient handoffs and reasons why errors occur. 3. Walk through a popular protocol to identify essential qualities of a good patient handoff. 4. Identify tips for effectively receiving a patient handoff.
Professionalism	**Sleep Deprivation**	1. Review the effects of sleep deprivation on physician performance and patient safety. 2. Provide background on the ACGME's resident duty hour requirements and review subsequent effects on patient care. 3. Identify ways physicians can mitigate the effects of sleep deprivation.
Professionalism	**Cultural Competency In Healthcare**	1. Review and describe the demographic statistics and shifts in the United States related to health and healthcare disparities. 2. Define the meaning of cultural competency and rationale in medicine. 3. Describe healthcare disparities and the impact on patient care. 4. Discuss successful physician-patient interactions.

IHI Module	Description
QI 102 **The Model for Improvement: Your Engine for Change**	This course will teach you how to use the Model for Improvement to improve everything from your tennis game to your hospital's infection rate. You'll learn the basic steps in any improvement project: setting an aim, forming a team, selecting measures, developing ideas for changes, testing changes using Plan-Do-Study-Act (PDSA) cycles, and measuring to determine if the changes you are testing are leading to improvement. **Estimated Time of Completion:** 1 hour 30 minutes
PS 101: Fundamentals of Patient Safety	This course provides an overview of the key concepts in the field of patient safety. You'll learn the relationship between error and harm, and how unsafe conditions and human error lead to harm — through something called the Swiss cheese model. You'll learn how to classify different types of unsafe acts that humans commit, including error, and how the types of unsafe acts relate to harm. Finally, you'll learn about how the field of patient safety has expanded its focus from reducing error to also encompass efforts to reduce harm. **Estimated Time of Completion:** 1 hour
PS 103: Teamwork and Communication	No matter how safe we make the design of systems in which we work, there is no substitute for effective teamwork and communication. In this course, you'll learn what makes an effective team. Through case studies from health care and elsewhere, you'll analyze the effects of teamwork and communication on safety. You'll learn essential communication tools, such as briefings, SBAR, and the use of critical language. Finally, you'll learn how to use these tools when they are most essential—at transitions in care, when errors are most likely to occur. **Estimated Time of Completion:** 1 hour
PS 104: Root Cause and Systems Analysis	This course introduces students to a systematic response to error called root cause analysis (RCA). The goal of RCA is to learn from adverse events and prevent them from happening in the future. The three lessons in this course explain RCA in detail, using case studies and examples from both industry and health care. By the end, you'll learn a step-by-step approach to completing an RCA after an error – and improving the process that led to the error. Note: Because RCAs are usually conducted in teams, it may be beneficial to take this course with a small group. **Estimated Time of Completion:** 1 hour 30 minutes
PS 105: Communicating with Patients after Adverse Events	You chose to work in health care in order to care for people. So when you accidentally harm a patient, it can be exceptionally hard to talk about it. In this course, you'll learn why communicating with patients after adverse events can feel so difficult for health care professionals – and why it's nonetheless essential. You'll learn what to say to a patient, and how to say it, immediately after such an event occurs. You'll also learn how to construct an effective apology that can help restore the trust between the caregiver and the patient. You'll find out what kinds of support both patients and caregivers may need after an adverse event. Finally, you'll consider how to communicate when an error causes minor harm to a patient or does not reach the patient at all. **Estimated Time of Completion:** 2 hours (CLER REQUIREMENT)