Interdisciplinary Patient Safety Certificate Program Prepares Health Professionals to be Effective Patient Safety Champions

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Presentation Objectives

• Describe the beneficial outcomes of building capacity in patient safety and quality through in-person and online training methods.

• Align the appropriate healthcare professionals with the competencies and skills needed to participate in and lead effective patient safety improvement efforts.
Background

• Effective patient safety leadership requires more than a passion for preventing harm.

• To thrive in this role, health professionals need a robust set of knowledge and tools to improve culture, effect behavior change, and fix broken care delivery systems.

• In response to this need, we have developed a Patient Safety Certificate Program to prepare health professionals to be effective patient safety champions.
Program Description

The Patient Safety Certificate Program is:

• 5-day program offered by the Armstrong Institute for Patient Safety and Quality

• Designed to build capacity among clinical practitioners dedicated to becoming leaders for patient safety and quality in their unit, clinic, or care facility

• Focused on the application of knowledge and skills in simulated patient safety challenges
Course Objectives

• Create and sustain a patient safety culture that has patient-centered care as its linchpin
• Apply evidence-based practices to develop and support effective multidisciplinary teams that work in partnership with patients and their families to improve patient safety outcomes
• Use a systems-based approach to identify and reduce defects
• Develop patient safety initiatives for real and lasting change
• Act as change agents in their organization as they lead efforts to continuously learn from defects and improve patient safety and quality care
Intended Audience

- Physicians
- Nurses
- Pharmacists
- Therapists
- Safety and Quality Improvement Officers
- Directors and Administrators who are members of healthcare organizations
Course Faculty

• Patient Safety and Quality Leaders
  – Physicians
  – Nurses
  – Risk Managers
  – Quality leaders
  – Pharmacists

• Faculty composition similar to the audience
Program Structure

• Pre-work – online “Science of Science” module
• In person problem-based learning sessions
• Networking to create learning and practice communities
• Forum to discuss issues specific to their work settings and tap into peer-to-peer learning
Day 1 – Safe Design Principles

• **Module 1:** The Science of Safety: Principles in practice

• **Module 2:** Patient Safety Culture: What is it? How do we improve it?

• **Module 3:** Patient-centered care
  – Patient-centered care Panel Discussion
Day 2: Developing and Nurturing High Performance Teams

- **Module 1:** Developing a high performance team
- **Module 2:** Communicating for patient safety
- **Module 3:** Leadership
- **Module 4:** Empowerment, conflict management
  - **Panel Discussion:** The role of the patient in a patient care team
- **Module 5:** CUSP readiness and overcoming CUSP barriers
- **Module 6:** Creating a culture that supports error reporting and disclosure
Day 3 – Learning from Defects

• **Module 1:** Risk management
• **Module 2:** Learning from Defects:
• **Module 3:** Identifying hazards, errors and risks
• **Module 4:** Prioritizing risks
• **Module 5:** Learning from Defects: Asking why a mistake occurred
  – Investigating Causes – Human Factors
  – Investigating Causes: Using Lean Sigma Tools
Day 4 – Designing and developing a Patient Safety Improvement Plan

- **Module 1**: Design thinking
- **Module 2**: Learning from Defects
- **Module 3**: Reducing hazards, risks and errors: Lean Sigma approaches
- **Module 4**: How will you know risk is reduced? Measuring Success
- **Module 5**: Quality Improvement measures: meeting industry standards
Day 5 – Developing Improvements and Sustaining Change

• **Module 1**: Lean Sigma approaches to sustaining change
• **Module 2**: Managing projects to keep improvement plans on track
• **Module 3**: Building momentum
• **Module 4**: Leading change
Program Implementation

• In-person program piloted February 2012 with 21 JH-based participants

• Since that time, the program has been offered 7 times between February 2013 and December 2014, with a total of 207 participants (internal to Johns Hopkins, n=151; external, n=56) earning certificates of completion

• Online program was introduced in September 2013, and to date 339 have enrolled and 174 participants have earned certificates of completion (internal to Johns Hopkins, n=91; external, n=83)
Program Evaluation

• Participant knowledge is assessed pre- and post-program using a 38-item instrument assessing knowledge in key patient safety areas.

• Post-program survey is conducted to identify participant satisfaction and strengths and opportunities for improvement in the program.
## Program Impact

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<th>Participant Knowledge</th>
<th>Pre</th>
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<td>64.83±13.64</td>
<td>93.51±6.56</td>
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Participant Feedback

"The program is ideal for someone who is coming from the frontlines and taking a position in patient safety. It's a very inclusive introduction to a wide range of safety concepts...There's no more effective way to get these concepts."

"I was able to network in small groups with colleagues from other institutions who were passionate about patient safety allowing for great exchange of ideas. The sessions were very comprehensive touching upon all facets of safety, including Six Sigma and Lean. I would recommend the [certificate program] to other colleagues."

"This was one of the best run and most practical courses that I have attended. The week just flew by. Great instructors with practical examples, and lots of camaraderie with other participants. It was a really terrific learning experience."
Conclusion

- Program evaluation demonstrated high levels of satisfaction with the program and improvements in knowledge in key areas of patient safety improvement.
- Patient safety initiatives, both in the United States and internationally, have used this program to prepare key organizational safety leaders and build their organizations’ internal capacity for improvement.
Questions?