

Patient Safety Education for Residents—A Colorado Story

To educate the next generation of physicians to be leaders in patient safety, we must give residents opportunities to identify and learn from mistakes. The Institute of Medicine raised awareness of medical errors in its 1999 landmark report,¹ and in 2008 advocated that “residents should be taught error detection, correction, reporting and monitoring so they can participate fully in the hospital’s quality improvement efforts.”²

During the past 2 years, 36 transitional year interns and 36 family medicine residents from 3 sites in Colorado participated in a comprehensive patient safety program. The curriculum requires each resident to report adverse events, report near misses or unsafe conditions, attend 12 patient safety lectures per year, and disclose a medical error to standardized patients in 2 separate exercises. Residents’ communication skills during the disclosure are rated by the standardized patients, and residents receive feedback from attending physicians who observe the exercise. Events reported by the residents are collected, deidentified, and analyzed, and education is provided to all residents in the program. Residents are surveyed before and after the intervention regarding their attitudes and assumptions about patient safety. This curriculum is modeled after the University of Illinois at Chicago’s Full Disclosure and Transparency Program.³

The experience from our program indicates that when residents are part of a culture of reporting and discussing mistakes, the fear of negative effects often associated with admitting or reporting a mistake is reduced. One resident stated, “I feel more confident about reporting incidents. Whereas [during] my first ward month I was unsure of reporting incidents that I thought were minor issues [now] I think reporting adverse events and near misses is more important than I previously thought, since seeing the actual changes that occur in response to our reports.”

During the 2 years, 94% of residents submitted an adverse event report. The longer the residents are part of the program, the more they report events. In 2009, residents reported a combined 147 events at the 3 programs. In 2010, 406 events were reported, an increase of 176%.

Of 553 total event reports, 165 were near misses and 141 represented unsafe conditions. Consequently, more than half of the reported events provided learning opportunities for residents and opportunities for system improvement before patients were harmed. Quality Improvement staff at the

hospitals reported that, previously, close calls were almost never reported and that the opportunity to learn from these near misses has been invaluable.

System changes that have occurred because of the resident reports include:

- Procedural changes regarding documentation
- Institution of a new policy regarding the safe transport of patients
- A change in practice to promote infection prevention
- Improved patient flow processes

Residents are highly satisfied with the curriculum and have demonstrated an increased comfort level in reporting and disclosing medical errors. Many have affirmed that they will be champions for safety in their careers going forward.

Our Patient Safety Education Program offers learning opportunities in the context of a comprehensive program for responding to adverse patient events. It has provided residents with valuable learning opportunities, allowing them to participate in quality improvement and gain experience in systems-based practice.

BRADFORD WINSLOW, MD, FAAFP

Residency Program Director, Swedish Family Medicine Residency, Assistant Professor of Family Medicine, University of Colorado School of Medicine

BRIAN S. BACAK, MD, FAAFP

Program Director, Rose Family Medicine Residency, Assistant Professor of Family Medicine, University of Colorado School of Medicine

BRIAN G. DWINNELL, MD, FACP

Associate Professor of Medicine, University of Colorado School of Medicine, Director, Graduate Medical Education, Presbyterian St. Luke’s Medical Center

SHELLY DIERKING, BA

CEO, Patient Safety Education Partnership, Denver, Colorado, shellydierking@psepartnership.org

Funding: This program is funded by The Colorado Health Foundation.

References

- 1 Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999.
- 2 Institute of Medicine. *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*. Washington, DC: National Academy Press; 2008.
- 3 McDonald T, Smith KM, Mayer D. “Full disclosure” and residency education. *ACGME Bulletin*. 2008;(May):5–9.