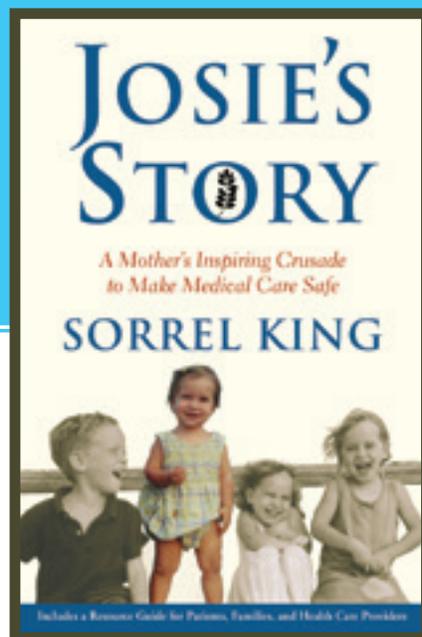




JOSIE KING FOUNDATION
creating a culture of patient safety, together

JOSIE'S STORY:

A PATIENT SAFETY CURRICULUM



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The story behind the Josie King Patient Safety Curriculum

In the winter of 2001, eighteen-month-old Josie King died from a series of preventable medical errors at one of the most renowned hospitals in the world. Eight years later, Grove Atlantic published *Josie's Story*, a recounting of this tragic event by Sorrel King. The book gained widespread popularity in medical and nursing schools along with hospitals around the country as a tool to not only educate future caregivers, but to inspire them as well.

As the powerful message of this story and its impact on readers became clear, Sorrel and the Josie King Foundation (whose mission it is to prevent medical errors from harming patients by creating a new and better culture within the healthcare industry) reached out to Karen Frush, the Chief Patient Safety Officer of the Duke University Health System. Karen and Sorrel shared the same fundamental understanding:

Facts provide us with knowledge – stories provide us with wisdom

Together they set out to form a patient safety curriculum that combined the power of the story and the science of safety with interactive and meaningful educational material. A team of educators was put in place, and the Josie King Patient Safety Curriculum was created.

The curriculum is made up of sixteen sessions, to align with a typical sixteen-week semester. It is designed to be utilized in many different settings, including medical and nursing schools, along with educators in the hospital environment who are in need of educational and inspirational patient safety material. It can be used in its entirety or as a single session to build upon existing patient safety/quality content.

The Josie King Patient Safety Curriculum is for the caregivers of the future. We hope this material provides knowledge and wisdom as they go forth into the world of healing.

Sorrel King

President and Co-founder
The Josie King Foundation



Karen Frush, MD, BSN

Professor Pediatrics
Clinical Professor of Nursing
Chief Patient Safety Officer
Duke University Health System



PATIENT SAFETY CURRICULUM SUMMARY TABLE

#	SESSION TITLE	LEARNING OBJECTIVES	SESSION FORMAT
1	Introduction to Patient Safety	<ul style="list-style-type: none"> ▪ Discuss historical background relating to patient safety ▪ Define health care “quality”, “medical error”, and “adverse outcome” ▪ Discuss the reasons for focus on patient safety 	<ul style="list-style-type: none"> ▪ Introductory lecture ▪ Possible unit observation exercise
2	<i>Josie’s Story</i> : Engaging Patients and Families for Safety	<ul style="list-style-type: none"> ▪ Discuss the role of the patient and family members in ensuring patient safety ▪ Describe a model Patient Advocacy Council or advisory committee ▪ Collaborate with patients and family members in support of optimal patient care ▪ <i>Optional</i>: Describe Condition H 	<ul style="list-style-type: none"> ▪ Video-triggered large group discussion, with patient panel
3	Anatomy of an Error	<ul style="list-style-type: none"> ▪ Discuss mechanisms of human error and limitations of human performance ▪ Describe the epidemiology of medical errors, including the most common types in selected disciplines and settings (e.g., inpatient, outpatient, surgical). ▪ Explain the Swiss Cheese Model of medical errors ▪ Participate in a root-cause analysis process, and suggest improvements. 	<ul style="list-style-type: none"> ▪ Group problem-solving exercise
4	The American Legal System and Patient Safety	<ul style="list-style-type: none"> ▪ State how most medical errors are classified within the legal system ▪ Outline legal concerns relating to medical errors and their disclosure ▪ Describe how potential legal ramifications impact disclosure and reporting 	<ul style="list-style-type: none"> ▪ Theory burst ▪ Structured small group work

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#	SESSION TITLE	LEARNING OBJECTIVES	SESSION FORMAT
5	Healthcare System Perspectives	<ul style="list-style-type: none"> Describe an overview of today's healthcare system in the U.S. Discuss the impact of medical errors on hospitals and healthcare organizations Consider the risks and benefits of disclosure at the hospital/healthcare system level including patients/family involved in the specific issue, impact on potential litigation and public relations 	<ul style="list-style-type: none"> Theory burst Small Group Discussions
6	Reporting Medical Errors	<ul style="list-style-type: none"> Reporting medical errors Describe error identification and reporting strategies, and their impact on quality Discuss the importance of reporting adverse events and how to do so in the local setting Discuss the significance of near-misses Demonstrate techniques for speaking up about a concern 	<ul style="list-style-type: none"> Presentation Small Group Discussion Q & A
7	Disclosure of Medical Errors	<ul style="list-style-type: none"> Outline key factors in appropriate disclosure Demonstrate appropriate technique for disclosure of a medical error 	<ul style="list-style-type: none"> Theory burst Small Group Discussions
8	Culture of Safety	<ul style="list-style-type: none"> Describe how organizational culture, blame, and emotional responses impact disclosure and reporting. Discuss how organizations, institutions, and health systems can create and maintain a culture of safety 	<ul style="list-style-type: none"> Online module Possible survey and discussion
9	Just Culture and Safe Choices	<ul style="list-style-type: none"> Discuss the concepts of individual accountability, safe choices, and "just culture" and how they relate to safety Demonstrate safe behavioral choices in patient care through small group discussions 	<ul style="list-style-type: none"> Theory burst Small Group Discussions

PATIENT SAFETY CURRICULUM SUMMARY TABLE

#	SESSION TITLE	LEARNING OBJECTIVES	SESSION FORMAT
10	The Second Victim	<ul style="list-style-type: none"> ▪ Discuss the impact of medical errors on healthcare workers ▪ Identify resources for support of health professional struggling with these issues 	<ul style="list-style-type: none"> ▪ Video ▪ Theory burst ▪ Panel discussion with Q & A
11	Rapid Response Teams and Condition Help	<ul style="list-style-type: none"> ▪ Describe Rapid Response Teams (RRT) and Condition H ▪ Articulate the pro and con positions of RRT and Condition H 	<ul style="list-style-type: none"> ▪ Video ▪ Presentation ▪ Theory burst ▪ Panel discussion with Q & A
12	Communication and Handoffs	<ul style="list-style-type: none"> ▪ Discuss the role of communication failures in unanticipated adverse events ▪ Describe key components of a safe and effective patient care handoff ▪ <i>Optional:</i> If practice session is included, demonstrate safe handoff technique 	<ul style="list-style-type: none"> ▪ Presentation ▪ Optional small group practice
13	Enhancing Teamwork to Improve Patient Safety	<ul style="list-style-type: none"> ▪ Discuss the role of teamwork and communication failures in unanticipated adverse events. ▪ Define and apply in-team situations: SBAR, critical language, check-back, huddles, debriefing, and situation monitoring 	<ul style="list-style-type: none"> ▪ Role-play exercise ▪ TeamSTEPPS™ tools

#	SESSION TITLE	LEARNING OBJECTIVES	SESSION FORMAT
14	Medication Safety	<p><i>Appropriate objectives for this topic may differ for different health professions.</i></p> <p>For prescribers: By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> ▪ Demonstrate proper prescription writing technique to minimize potential for error ▪ Use only approved abbreviations when writing prescriptions or orders ▪ Apply safe techniques when dealing with sound-alike or look-alike medications ▪ Discuss the importance of taking a thorough medication history <p>For non-prescribing professions: By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"> ▪ Discuss essential characteristics of safe medication orders ▪ Apply safe techniques when dealing with sound-alike or look-alike medications ▪ Outline safe procedures for dispensing / administering medications 	<ul style="list-style-type: none"> ▪ Presentation ▪ Small Group Discussion
15	Mistake-Proofing Care	<ul style="list-style-type: none"> ▪ Define the six methods for mistake-proofing care ▪ Discuss the importance of, and methods for, layering error-proofing methods ▪ Discuss the role of clinical guidelines in mistake-proofing care ▪ Discuss patient involvement as a necessary part of error-proofing 	<ul style="list-style-type: none"> ▪ Online module ▪ Application exercise
16	Life Lessons: Application	<ul style="list-style-type: none"> ▪ Identify chosen safe practices for chosen career area ▪ Discuss strategies for influencing safety culture in the chosen work setting ▪ Identify obstacles that present opportunities ▪ Choose personal goals for the future 	<ul style="list-style-type: none"> ▪ Presentation ▪ Small Group Discussion

Session Format: Video-triggered large group discussion with patient panel

Session Objectives: By the end of this session, participants will be able to:

- Discuss the role of the patient and family members in ensuring patient safety
- Describe a model Patient Advocacy Council or advisory committee
- Collaborate with patients and family members in support of optimal patient care
- *Optional:* Describe Condition H



SUGGESTED READINGS

Prior to this session, learners should prepare by reading *Josie's Story*:

- Prologue through Chapter 4 (prologue through Chapter 3 may have been read earlier)
- Review Resource Guide, Part 1

Additional resources for those desiring further learning:

- National Patient Safety Foundation tools and resources for patients: Fact sheets and other materials for consumers - bit.ly/12M6iFu
- Consumers Advancing Patient Safety: Materials to empower patients - bit.ly/12gakCL
- The Joint Commission: Speak Up initiative - bit.ly/1cHegBh
- Centers for Disease Control and Prevention: 10 Things You Can Do to be a Safe Patient - 1.usa.gov/12gaGJt
- Safe Care Campaign: How to Receive Safe Care - bit.ly/15XYApG
- Campaign Zero - bit.ly/15XYZlv
- The Empowered Patient Coalition - bit.ly/14IKokT
- Bailey E. *The Patient's Checklist: 10 Simple Hospital Checklists to Keep you Safe, Sane, and Organized.* New York: Sterling Publishing, 2011.
- Curtiss K. *Safe and Sound in the Hospital: Must-Have Checklists and Tools for your Loved One's Care.* Lake Forest, IL: PartnerHealth, 2011.

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ATTACHMENTS

Documents for this session:

- Faculty Facilitator's Guide
- Instructions for Panelists



POTENTIAL ADDITIONAL MATERIALS

- Josie's Story video, as told by Sorrel King, October 2002
Josie's Story (DVD) included in curriculum binder. Additional copies are available by contacting the Josie King Foundation.

Objectives: By the end of this session, students will be able to:

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- Describe a model Patient Advocacy Council or advisory committee
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- *Optional:* Describe Condition H

1 Opening (5 min)

- Open the session, making connection to previous session(s)
- Give overview:
 - › This session is about the role of patients and families in helping us ensure safe care
 - › Start with a short video, followed by discussion with local experts

2 Video (15 min)

- 15-minute clip of Sorrel King telling Josie's story
- Ask students to pay attention to the sequence of events, and how the staff responded to the mother whenever she raised a concern

3 Team Caucus (10 min)

- Ask students to take a few minutes to discuss in clusters what they just saw (either in preassigned groups or trios/small groups seated near one another)
 - › What problems can you identify?
 - › How many were picked up by the mom?
 - › What happened when she spoke up?
 - › Why do you think that happens?

4 Large Group discussion (20 min)

- Facilitate discussion of questions
 - › Why do health professionals tend to resist family requests?
 - › How do we bring patients and family members into the core of care teams?
 - › Need to better collaborate in the best interest of patients
- Consider sequence of events in *Josie's Story*
 - › Mother concerned, asked nurse to call doctor, reassured

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- › Mother asked for another nurse to check, reassured
- › Mother more concerned, demanded doctors to see
- › Mother remained concerned, asked doctors to stay nearby
- › Mother questioned medication, reassured, med given
- Discussion may generate questions for panelists

5 Panel (15-minutes for comments, then Q & A discussion)

In advance, recruit two to four patients and/or family members with experience in the health care system. Ideally, these are members of a Patient Advocacy Council or other advisory group, but any patients who are willing to share their story with a large group may be used. It's generally worthwhile to speak with panelists in advance to hear their story and guide them on the desired focus. Panelists should sit in the room for the video and discussion to give them a sense of the students' perspective before they speak.

- Allow panelists to introduce themselves.
- Ask each to comment briefly on what they've heard, and their own experiences (5 minutes each is appropriate)
 - › Have you ever tried to speak up about a concern regarding health care?
 - › What happened? How was your input received?
 - › What role do you think patients and families can play in patient safety?
 - › What do you think physicians can do to improve communication with patients and families?
- Questions from students and responses from panelists

6 Optional: Condition H (5 min)

- Patients/families have the ability to call for help if they have a concern that isn't being addressed to their satisfaction
 - › Discuss status in home system - in place? How accessed?
 - › Is the phone number posted in hospital rooms?
- Activates Rapid Response Team
- Allow brief discussion of panelists' experiences with Condition H, if they are familiar or have used.

7 Closure (5 min)

- Generate list of take-home points from panel and audience
 - › Trust instincts - especially a mother's
 - › "Listen" to the patient (even if they're not talking); i.e., treat the patient, not the numbers

- “Not all the answers are on clipboards and computers”
- Thank panelists for their time and willingness to share

Total duration: 90 min-2 hours, depending on time allowed for discussion. The duration can be shortened by assigning steps 2 and 3 as homework in advance of the session.