The Patient Safety Education Program™
CANADA

Plenary 2: External Influence: Issues of Law, Capacity & Policy

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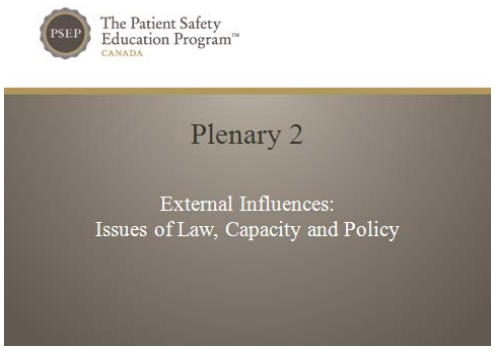
PSEP – Canada Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of: • The role of the external environment in shaping the safety work of organizations and microsystems • The importance of alignment between organizations and external factors • The mismatch between the fault based malpractice system and systems based approaches to promoting patient safety The performance elements include engaging in exercises to: • Describe the hierarchy of systems needs set forth in *Crossing the Quality Chasm* • Describe roles the media can play in supporting systems-based approaches to safety • Describe the role the legal system can play in supporting systems-based approaches to safety • Describe roles governments or employers can play in supporting systems-based approaches to safety	**Domain: Contribute to a Culture of Patient Safety** *2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:* 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices **Domain: Recognize, respond to and disclose adverse events** *3. Health care professionals who disclose the occurrence of an adverse event to patients and/or their families as appropriate and in keeping with relevant legislation:* 3.2. Recognize the ethical, professional and legal obligation to disclose and report adverse events 3.4. Are aware of existing policies and procedures associated with disclosure and the extent to which these foster a culture of patient safety 3.12. Recognize the need for a just culture of safety in supporting disclosure and reporting 3.13. Appreciate the legal implications arising from disclosure

Abstract

Slide 1



This plenary investigates the interaction between healthcare organizations and several external stakeholders who shape behaviours within such organizations and their microsystems (small units of work that actually give the care that the patient experiences). Examining the impact of the external environment is crucial to understanding barriers to change that impede the advancement of systems-safety approaches. Opinion leaders now call for alignment of these sectors behind the healthcare system's systems transformation agenda. Vertical integration across stakeholders is examined in this model, and the roles of specific stakeholder groups such as media, patient and regulators is explored. One of the focuses of the module is the fault-based malpractice system which is mismatched with patient-centered, systems-based improvement strategies.

Keywords

Accountability, accreditation, disclosure, educator, employer, fault, horizontal integration, media, negligence, professional discipline, regulation, disclosure, transparency, reporting, supply chain, vertical integration.

Teaching method

Didactic

Objectives

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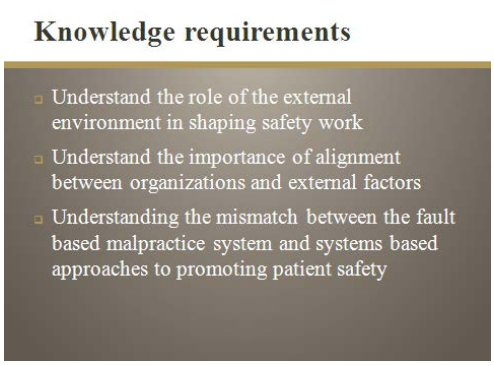

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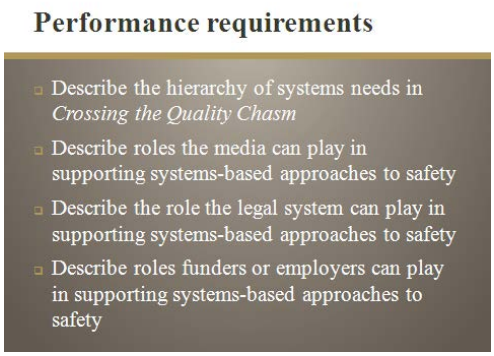

Knowledge elements

The knowledge elements include an understanding of:

- the role of the external environment in shaping the safety work of organizations and microsystems;
- the importance of alignment between organizations and external factors; and
- the mismatch between the fault based malpractice system and systems based approaches to promoting patient safety.

Performance elements

The performance elements include engaging in exercises to:

- describe the hierarchy of systems needs set forth in *Crossing the Quality Chasm*;
- describe roles the media can play in supporting systems-based approaches to safety;
- describe the role the legal system can play in supporting systems-based approaches to safety; and
- describe roles governments or employers can play in supporting systems-based approaches to safety.

Introduction

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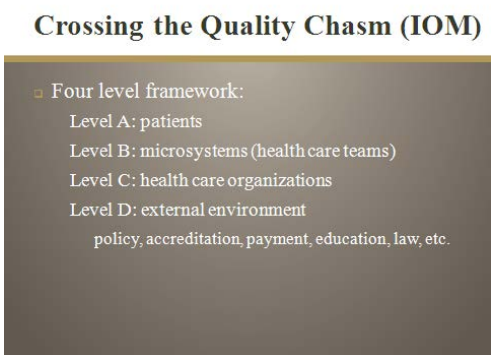

With the publication of the Institute of Medicine's *To Err is Human* and *Crossing the Quality Chasm* reports, the discussion of preventable harm reached a new plateau from which the vista of the challenge before us can be more clearly seen. Responding to the IOM's call to action and driven by related healthcare concerns of access, quality, efficiency and effectiveness, the patient safety movement has recruited a host of new constituencies beyond clinicians, each of which are exploring, describing, analyzing and beginning to act to address the challenge in their own fields of influence. The actions or inaction of these stakeholders which include legislators/governments, regulators, accreditors, standard setters, employers, health insurance companies, patients, product manufacturers, educators, lawyers and the media, among others, constitute what *Crossing the Quality Chasm* report has called the environment of care. These are the external factors that shape behaviours of and in organizations that deliver care.

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Interactions with these external constituencies are often uncomfortable for providers, and hence resisted. Looking back at the history of the patient safety movement so far, it appears that this lack of alignment has been an impediment to making progress in reducing harm. We have no real evidence of progress, and it is universally agreed among opinion leaders that this goal has not been reached, with researchers and clinicians suggesting rates of harm may have actually increased. Moreover, key aspects of the

external environment –governments and media, among others – have, if anything, increased the volume in its demand for adverse event -free performance.

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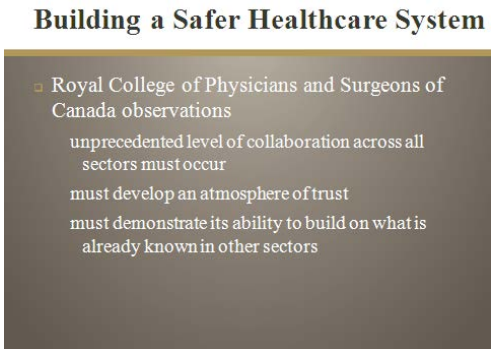

In addition, a 2002 Royal College of Physicians and Surgeons of Canada Report entitled Building a Safer Healthcare System (http://rcpsc.medical.org/publications/building_a_safer_system e.pdf) made several statements and recommendations for building a safer system in Canada. Among them, the RCPSC observed that:

- an unprecedented level of collaboration across all sectors must occur to ensure a co-ordinated and effective strategy for improving patient safety;
- the healthcare system must develop an atmosphere of trust, in which openness and frankness in identifying and reporting problems or potential problems is encouraged and rewarded; and
- the healthcare system must demonstrate its ability to build on what is already known in other sectors, learn from experience, and be willing and able to implement major reforms when indicated.

How, then, do we move forward in advancing the safety of the healthcare system? This module describes some aspects of the external environment and offers thoughts on the emerging roles and accountabilities of the numerous stakeholders in patient safety.

Views on external alignment

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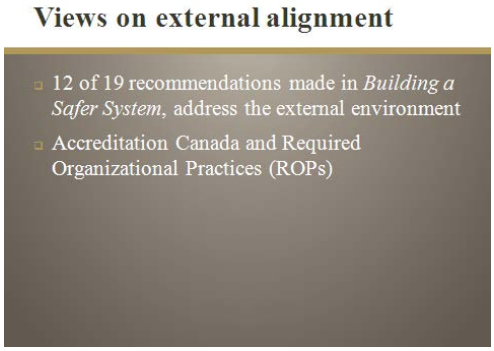

Twelve of nineteen recommendations made in *Building a Safer System*, address the external environment, such as:

1. standardize the legislation on privacy and confidentiality of personal health information across Canada to facilitate access to patient-safety data, while respecting the privacy of patients and providers;
2. develop a greater focus on improvement through education and remediation, vs. blame and punishment, in legal, regulatory and human resource processes;
3. review, and where applicable, revise The Evidence Act and related legislation within all Canadian jurisdictions to ensure that data and opinions associated with patient safety and quality-improvement discussions, related documentation and reports are protected from disclosure in legal proceedings, and the protection would extend to this information when used internally or shared with others for the sole purpose of improving safety and quality (wording within the applicable Acts should ensure that all facts relating to an adverse event are recorded on a health record that is accessible to the patient or designated next of kin, and are not considered privileged);
4. hold further discussions regarding the tort and healthcare insurance systems and their effects on patient safety, with the aim of making recommendations that would contribute to a culture of safety in Canadian healthcare;
5. undertake an analysis of the capabilities and cost of systems for monitoring adverse events, critical incidents and near misses;
6. recommend the types of surveillance systems, including relevant patient-safety indicators, to be developed and supported in Canadian healthcare. The recommendations would be based on the findings of the review proposed in Recommendation 11;
7. secure funding from federal/provincial/territorial jurisdictions to invest in information technology infrastructures that support the standardized identification, reporting and tracking of patient-safety data;
8. adopt “patient safety” as a cross-cutting theme or designated area for research competitions supported by the Canadian Institutes for Health Research, Canadian Health Services Research Foundation and/or other granting organizations, to encourage Canadian researchers to undertake studies in this area;
9. develop and implement healthcare education and professional-development programs for improving patient safety;
10. develop educational and continuing professional development programs to improve patient safety in collaboration with national accrediting bodies, academic institutions, provincial licensing authorities (for peer-assessment reviews) and healthcare facilities/organizations/scholarly societies;
11. publicly report measures of healthcare quality and safety; and
12. develop educational materials on personal measures for improving safety in healthcare for distribution to the public.

Additionally, Accreditation Canada has distinguished itself as a voluntary mechanism to drive safety that resides in the external environment. The focus on safety is supported through Required Organizational Practice (ROP) which is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk.

ROPs have been identified in six patient safety areas:

1. Safety Culture;
2. Communication;
3. Medication Use;
4. Worklife/Workforce;
5. Infection Control; and
6. Risk Assessment.

There are 35 ROPs total in those six areas. To receive accreditation, national client organizations must comply with all ROPs that apply to the services they provide.

Clearly the focus on external factors signals that experts believe improvements in safety will be incremental absent alignment of external with internal influences in healthcare. Organizations will continue to be distracted with the multiple competing demands for activity, measurement and reporting that is confusing, redundant and frustrating to patients, healthcare providers and administrators. Alternatively there are emerging examples of how alignment of resources can target and address an issue successfully. The example of implementation of the surgical checklist in Canadian hospitals is an interesting case study.

A tool for improving the safety of surgery was created by experts working with the World Health Organization and launched in concert with evidence presented in the New England Journal of Medicine (NEJM) article on the effectiveness of the tool, specifically the surgical safety checklist (Haynes, Weiser, Berry, et al, 2009). This led to a Canadian initiative supported by the Canadian Patient Safety Institute (CPSI), a working group and a Special Advisor who was one of the researchers and authors of the NEJM article.

Members of the working group were interdisciplinary and included healthcare professionals, accreditors, researchers, communicators and professional organizations for an initial campaign focused on increasing organizational awareness of the initiative and providing supports for implementation of the tool. This was followed with the development and implementation of an Accreditation Canada ROP related to implementation and use of the Checklist in a manner consistent with its intended purpose. As the tool became more common place at least one Canadian province began to mandate its use and publicly report on compliance.

The *Crossing the Quality Chasm* framework

Also lodged in cognitive engineering principles, *Crossing the Quality Chasm* makes clear that patient safety is part of a larger picture, placing it in the context of a vertically

integrated hierarchy. The report sets forth an agenda of needed changes in healthcare through a four level framework:

1. the experience of patients (Level A);
2. the functioning of small units of care delivery (or "microsystems") (Level B);
3. the functioning of the organizations that house or otherwise support microsystems (Level C); and
4. the environment of policy, payment, regulation, accreditation, and other such factors (Level D) that shape the behaviour, interests, and opportunities of the organizations at Level C.

Berwick has described Level A as "true north," because the experience of patients, their loved ones, and the communities in which they live are paramount. Berwick describes Level B's microsystems as “small units of work that actually give the care that the patient experiences…A cardiac surgical team is a microsystem; so is the night shift in an emergency department; so is a small clinical office practice; and so, in the information age, is the team that designs a Web page for patients with multiple sclerosis. The microsystem is where the work happens; it is where the "quality" experienced by the patient is made or lost.” Levels B through D essentially serve Level A.

Changes at environmental level (Level D)

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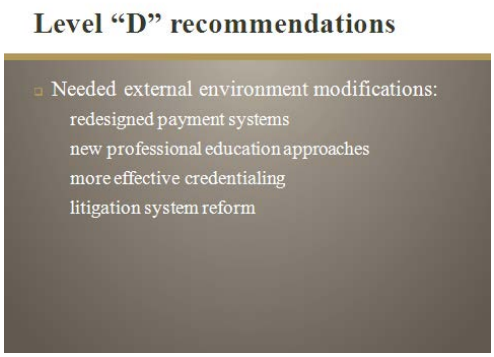

Don Berwick has observed that at Level D, *Crossing the Quality Chasm* “offers many more questions than answers.” Its specific recommendations focused mainly on payment systems as a way to incentivize or remove barriers to achieving safer, higher quality care and a research and pilot projects agenda to investigate financial barriers more fully. It also suggests system-wide research and redesign of professional education, credentialing, and the litigation system to better align these drivers to incentivize safety with organizations and their Microsystems.

Alignment between a systems approach & litigation reform

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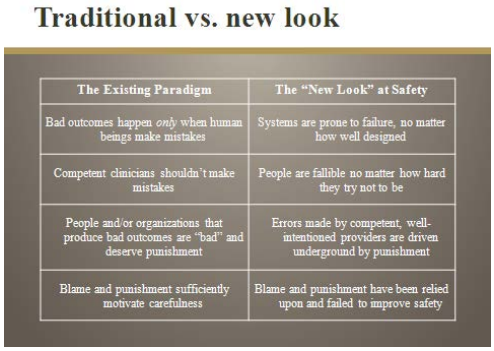
Slide 11



A major challenge in the external environment is transforming the way in which our society thinks about accountability for safety and develops public policy to ensure it. We are currently operating from a deeply-rooted notion of civil justice & fairness which accepts as truth that (1) clinicians and others engaged in the provision of health services who harm patients *deserve* punishment and (2) that fear of punishment *deters* individuals from making mistakes. In Canada litigation remains the relatively rare event. Regardless, what remains is a legal system focused on assessing blame and punishing mistakes, despite an accumulation of evidence that this deterrence approach is unsuccessful in its explicit goals of preventing patient harm.

Although notable in the United States (US), the development of an apparent increase in criminal prosecutions in the 1990s for bad medical outcomes has not translated to the Canadian context. Fifteen physicians [have been] charged with manslaughter or criminal negligence causing death or causing grievous bodily injury as a result of alleged negligence in their professional practice between the years 1900 and 2007 (MacDonald, 2008).

Table 1 outlines the basic premises of the existing paradigm driving our safety activities and the "new look" at healthcare safety now being driven by a systems-based approach. Finding opportunities to contrast these two disparate constructions and challenge the presumptions of the "old look" can be useful in creating new ways of thinking about safety as a systems issue among all stakeholder groups.

In contrast, the commercial aviation industry has done an exceptionally good job in integrating these principles into the consciousness of passengers, who at the beginning of every flight are reminded that there are inherent risks associated with air travel. The routine reinforcement of this message also conveys that ensuring safety is a high priority of the airline industry and that the industry "cares." It is however recognized that the airline industry is somewhat simplistic when compared to the complexity of delivering healthcare services to an ill or ailing human being.

Table 1: The new approach to safety

The Existing Paradigm	*The "New Look" at Safety*
• Bad outcomes happen *only* when human beings make mistakes	• Systems are prone to failure, no matter how well designed
• Competent clinicians shouldn't make mistakes	• People are fallible no matter how hard they try not to be
• People and/or organizations that produce bad outcomes are "bad" and deserve punishment	• Errors made by competent, well-intentioned providers are driven underground by punishment
• Blame and punishment sufficiently motivate carefulness	• Blame and punishment have been tried and failed to improve safety

Communicating that human actors in the healthcare system, especially highly trained professionals, are fallible and prone to error is a harder message for audiences operating from the old paradigm to hear. It may generate initial distrust or discomfort, a natural stage as people shift from one way of thinking to another. But it is a crucial point to get across if we are to dissemble the belief that human beings can be motivated to be perfectly careful by the fear of liability or punishment. Once our audiences accept, as a matter of science, that the most conscientious of clinicians are unable to prevent their own mistakes all of the time, we will reach a new plateau in the public understanding of risk and a new readiness to consider systems-based approaches to accountability.

Related to the notion that risk, much of it latent and unseen, is inherent in the healthcare process is the fact that the best designed systems also are fallible and susceptible to breakdown. An initial reaction to this statement may well be discomfort and feelings of extreme vulnerability among audiences unfamiliar with safety science. But, again, reinforcing the ubiquity of risk in all human endeavors is a necessary step to enlisting patients, the media, policymakers, funders and other external audiences as allies in assisting the healthcare system in managing risk. Just as the initial safety message on commercial airline flights reminds passengers that, in the case of an emergency, they have responsibilities as members of the safety team, providers' willingness to explicitly discuss inherent risks in healthcare is a prelude to holding external audiences accountable for their roles in advancing safety.

Realigning to a shared mental model of safety and accountability

Crossing the Quality Chasm's message is that for a system to reduce failure and harm there must be alignment of incentives, priorities and values across all levels of the system – in short a shared mental model. As healthcare renews its vow to "First, do no harm," the next step in the argument is that the external environment should follow suit. Some potential questions from this assumption include:

- Is it realistic to expect hospitals to invest resources toward the prevention of harm when funding policies provide no encouragement to do so?
- Can we honestly encourage clinicians to flush out their mistakes if their licensing authorities continue to equate errors with incompetence and reply with professional discipline?
- Will we ever move beyond blame and liability so long as patients who have been harmed have no alternative but to sue to be compensated for losses?

These questions underscore that the alignment of goals and priorities cannot stop and start at the hospital door. Performance in healthcare certainly is shaped by our existing notions of hazard, accountability and blame. Redesign of the system in accordance with the recommendations of the IOM or other prescriptions for quality improvement cannot optimally be achieved unless this paradigm shifts. If we are to be successful in optimizing patient safety, we need a new model of shared accountability that encompasses both the healthcare system and the external environment where expectations and demands on the health system performance are established.

The time has come for safety advocates to reexamine no-fault programs, enterprise liability (criminal liability imposed on the entire firm for the crime committed by a constituent business, department, or unit) and other models for civil justice reform that appear to incorporate systems-based thinking. The exercise should start by asking a variation on the same question posed to healthcare: what model for addressing medical liability claims best prevents or mitigates unnecessary harm to patients? In other words, would legal reform cost lives or save lives?

Indeed this could be the basic question for every external stakeholder that serves a "blunt end" function in healthcare. Achieving true high reliability operation in healthcare will necessitate growing an expanded appreciation of all interlinked roles in shaping, paying for, delivering and receiving healthcare services. Taken together, these stakeholder groups constitute a mutually dependent system which works well only when each layer operates with aligned incentives and values. The following outlines one perspective on key roles and responsibilities, and is offered as a starting point for discussion.

Roles of law and government

Slide 12

Legislators, regulators, judges, lawyers and legal scholars play primary roles in defining accountability. If we as a society are serious about transforming healthcare into a culture that pursues the prevention of harm as the highest priority, resources must be provided, and legal and regulatory requirements must be adjusted. Knowledge about patient safety incidents will not be flushed out unless there exists some safe place to report and analyze failure that will not trigger penalties for the person who reports. Specific responsibilities of this segment include:

- creating safe harbors (protected from discovery in litigation) for reporting patient safety incidents;
- establishing and enforcing threshold requirements for the delivery of safe care;
- legally enabling individuals and jurisdictions in healthcare to share information and collaborate in strategies that promote patient safety without fear of breaching legislation;
- making government resources available for patient safety research;
- fairly, respectfully and efficiently compensating patients and families harmed by avoidable error; and
- applying systems thinking to the evaluation of human and organizational performance conducted by licensure and disciplinary authorities.

The role of media

Slide 13

Representatives of the media often claim to be uninvolved reporters of information, but in fact they shape the attitudes of all stakeholders. Specific media responsibilities include:

- promoting patient awareness about the inherent riskiness of healthcare service delivery and the day to day challenge of managing risk;
- transferring knowledge about safety to policymakers, consumers, and all other audiences that can use it;
- reporting catastrophic incidents, which offer valuable preventive lessons; and
- maintaining the spotlight to discourage complacency and underscore the importance of keeping safety a top priority.

Role of employers and funders

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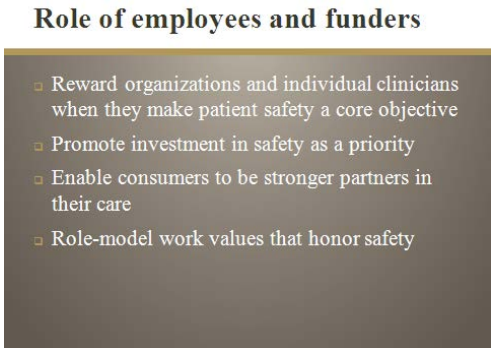

Funders of healthcare services can leverage performance expectations and the allocation of resources in healthcare. They can help align organizational behaviour along the tenets of systems and complexity theory by:

- establishing financial incentives that reward organizations and individual clinicians through fee schedules when they make patient safety a core objective;
- aligning funding strategies to promote investment in safety as a priority, even if those investments do not generate immediate savings;

- educating patients about healthcare risks, and providing information that enables them to be stronger partners in their care; and
- role-modeling work values that honor safety.

Role of product supply chain

Slide 15

Purchasers of medical devices, pharmaceutical agents and biomedicals can use their buying power to drive investment in safety by product manufacturers and sellers. The responsibilities of this supply chain include:

- purchasers adopting patient safety as a core product attribute in all their purchasing decisions;
- purchasing agents in healthcare systems seeking and incorporating user (clinician and patient) feedback in contract decision-making;
- product makers/sellers fostering innovation in design, packaging and labelling; and
- disseminating post-marketing product discoveries that potentially saves lives.

Role of educators

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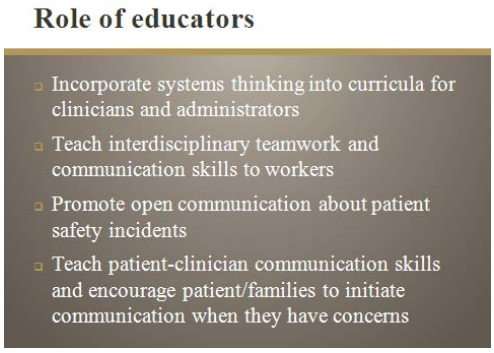

Moving beyond individual blame for patient safety incidents to a systems perspective is counter-intuitive, and opposed by many who believe it dilutes accountability. Achieving a culture of safety requires introducing new behaviour norms at the entry point into a

career in healthcare as well as skills building for current clinicians and administrators. Necessary educational efforts include:

- incorporating systems thinking and quality improvement into curriculums of clinicians and health system administrators;
- teaching interdisciplinary teamwork, communication and feedback skills to new and practicing clinicians;
- facilitating open communication about patient safety incidents with colleagues; and
- teaching patient-clinician communication skills and encouraging patients and families to initiate communication when they have safety concerns.

Role of patients

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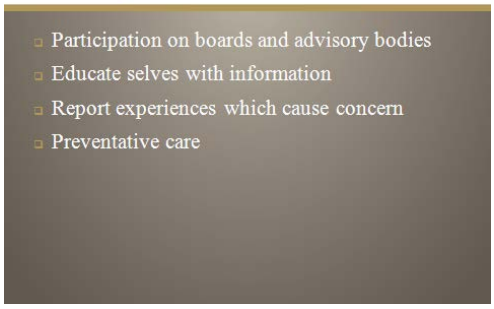

Patients play important roles in establishing safety as a core value, even when they are not actively seeking medical treatment. Indeed, we may be more effective at demanding change or fighting complacency about safety when we are not in the vulnerable position of being patients or worrying about a loved one who is. Patient contributions include:

- participating on healthcare organization boards and advisory bodies;
- educating ourselves with information about our health;
- reporting our experiences in interacting with the healthcare system – successes and patient safety incidents – back to the organization delivering the services and/or regulatory authorities through available feedback channels; and
- working to stay healthy.

These roles and responsibilities represent an initial attempt to describe a scheme of shared accountability for safety. Surely they will be adjusted as discussion in the patient safety community continues.

Summary

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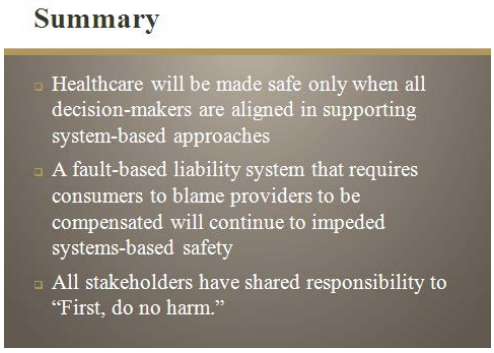

Healthcare will be made safe only when all decision-makers are aligned in supporting system-based approaches. Efforts to improve safety within healthcare organizations require vertical integration with the external environment. A fault-based liability system that requires patients to blame providers to be compensated may impede systems-based safety. All stakeholders have a shared responsibility to "First, do no harm."

Potential pitfalls

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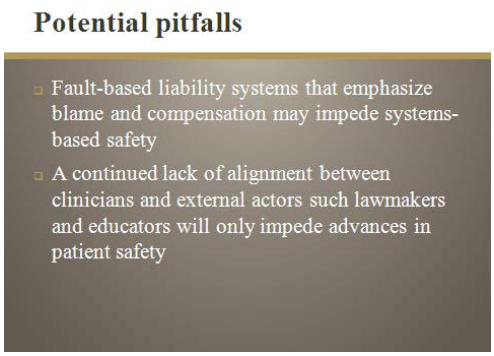

1. Fault-based liability systems that emphasize blame and compensation may impede systems-based safety
2. A continued lack of alignment between clinicians and external actors such legislators and educators will only impede advances in patient safety.

Pearls

Slide 20

1. Effective communication after a harmful incident can meet patient needs and reduce liability exposure.
2. We need better communication techniques to move forward
3. No-fault approaches that split compensation from accountability have removed significant barriers between patient and provider

Toolkits & outcome measures

- **Health Care Quality Improvement: Ethical and Regulatory Issues**: Jennings B, Baily MA, Bottrell M, Lynn J (eds). Garrison, NY: The Hastings Center; 2007. http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/HealthCareQIEthicalandRegulatoryIssues.htm

Resources

- **Crossing the Quality Chasm: A New Health System for the 21st Century**: Committee on Quality of Health Care in America, Institute of Medicine, Washington, DC, USA: National Academies Press; 2001 http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/CrossingtheQualityChasmANewHealthSystemforthe21stCentury.htm
- **Governance for Patient Safety: Lessons from Non-Health Risk-Critical High-Reliability Industries:** One of six reports commissioned by Health Canada's Health Policy Research Program (HPRP), under the category "Governance Choices and Health Care Quality: A Focus on Patient Safety".
  http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2005-sheps-eng.php
  http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2005-sheps-fra.php

- **Patient Safety Law: From Silos to Systems:** One of six reports commissioned by Health Canada's Health Policy Research Program (HPRP), under the category "Governance Choices and Health Care Quality: A Focus on Patient Safety". http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2006-downie-eng.php
  http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2006-downie-fra.php
  http://www.energyk.com/healthlaw/
- **Patient Safety, Medical Error and Tort Law: An International Comparison:** One of six reports commissioned by Health Canada's Health Policy Research Program (HPRP), under the category "Governance Choices and Health Care Quality: A Focus on Patient Safety".
  http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2006-gilmour-eng.php
  http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/2006-gilmour-fra.php
  Full report available at: http://www.osgoode.yorku.ca/faculty/Gilmour_Joan_M.html

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Plenary 2 Trainer's Notes

Principal message

The single most important message your audience should come away with is that the *fault-based malpractice system* is mismatched with *patient-centered, systems-based improvement strategies*.

Plenary overview

This plenary investigates the interaction between healthcare organizations and several external stakeholders who shape behaviors within such organizations and their microsystems. Examining the impact of the external environment is crucial to understanding barriers to change that impede the advancement of systems-safety approaches. Opinion leaders now simultaneously call for additional pressure for reform from sectors such as government, reimbursement and education and, on the other hand, alignment of these sectors behind the healthcare system's systems transformation agenda. Vertical integration across stakeholders is examined in this model, and the roles of specific stakeholder groups such as media, consumer and regulators is explored.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	40 minutes
Summary	2-3 minutes
Evaluation	5 minutes
Total	49-51 minutes

3. Number of slides: 20

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP – Canada Front Cover Page**;
- **PSEP – Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the slides cannot be shown, you can refer to the hand out slides, and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: didactic lecture

This module was designed to be presented as a lecture without much audience interaction. Use the slides to trigger the subject. Prepare ahead and practice so that it is smooth and interesting. The use of your voice, body language, and gestures can all add to your presentation and the clarity of the message you are delivering.

5. Key take-home points

1. Patient safety research must account for both the horizontal and vertical integration of healthcare institutions and systems.
2. Blame and punishment fail to improve safety.
3. Risk is inherent in the healthcare process and even the best designed systems are fallible and susceptible to breakdown.
4. Fault-based liability systems that emphasize blame and compensation impede systems-based safety.
5. A continued lack of alignment between clinicians and external actors such as lawmakers and educators impedes advances in patient safety.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this plenary and to evaluate the session in the provided brief questionnaire.