



**NATIONAL ACTION ALLIANCE**  
for Patient and Workforce Safety

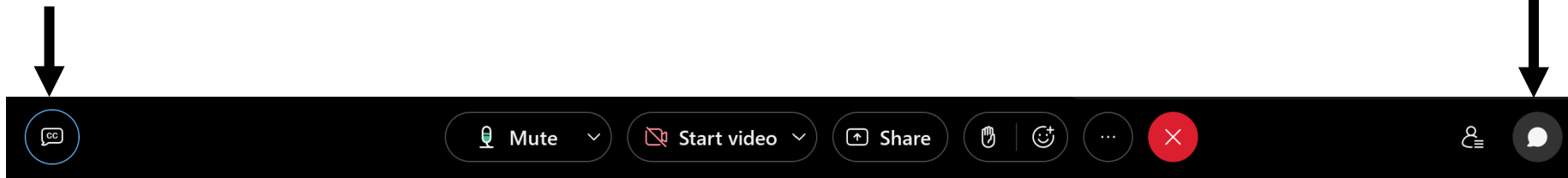
# Empowering Frontline Staff with Competencies for Patient Safety

**NATIONAL WEBINAR SERIES**

August 20, 2024

# Housekeeping Instructions

- This webinar will be recorded and available for viewing on the NAA website
- Please use the 'Chat' function to engage with us throughout to webinar and to ask any questions.
- Closed Captioning (CC) is available.



# Questions to Run On

- What are safety competencies, and how can they support safety culture and practice?
- How can healthcare organizations effectively support safety competencies in their clinical teams?

# Share With Us

Which safety competencies would you most like to develop or reinforce in your organization to prevent harm?

# Speaker Welcome



**Jenn Schreiber, MSN, MBA, RN, CPPS, CPHQ**  
Principal Healthcare Analyst and Qualitative Analysis Lead, Ripple Effect



RIPPLE EFFECT™

# Five Aims of the National Action Alliance for Patient and Workforce Safety

## Total Systems Approach to Safety Informed by Safety Self-Assessments



## Learning and Research Network

- 1. Advance Organizational Safety Strategies Using Safety Self-Assessments**
  - Focus on four safety foundational areas: culture, patient engagement, workforce safety, learning systems
  - Make commitment
  - Perform safety self-assessments
  - Enact safety strategy based on identified gaps
- 2. Empower the Patient's Voice in Safety Strategy**

For example:

  - Safety event submissions
  - Inclusion in event review
  - Input on safety initiatives
  - Communication and resolution programs
- 3. Support Healthcare Workforce by Making Healthcare Safer by Design**
  - Address five high-priority safety engineering needs
- 4. Support Healthcare Workforce by Strengthening Safety Competencies**
  - Identify lessons learned and potential gaps in existing competencies or their implementation
  - Support organizations in the adoption of evidence-based competencies for all
- 5. Facilitate Learning and Research Network**
  - Encourage learning and sharing across the network
  - Spotlight change leaders
  - Promote robust measurement
  - Research to address high-priority needs

## National Action Alliance Aim #4: Support Healthcare Workforce by Strengthening Safety Competencies

- The National Action Alliance Safety Competencies Affinity Group provides a forum for exploring existing safety competencies to support healthcare workers in improving safety practices and culture
- The Group seeks to review existing competencies, acknowledge areas of commonality, overlap, and differences, and understand the potential significance and implications of differences
- Finally, the Group seeks to identify potential gaps in existing competencies or their implementation

# Safety Science

- Knowledge about safety-related phenomena, processes, events<sup>1</sup>
- Concepts, theories, frameworks, approaches, principles, and methods for the understanding, assessment, characterization, management, governance, and communication of safety<sup>1</sup>
  - ▶ Safe design principles and team decision-making<sup>2,3,4</sup>
  - ▶ System-level factors<sup>2</sup>
  - ▶ Safety as a system property<sup>2</sup>



1- Terje Aven, What is safety science?, Safety Science, Volume 67, 2014, Pages 15-20, ISSN 0925-7535, <https://doi.org/10.1016/j.ssci.2013.07.026>.

2- Understand the Science of Safety. Content last reviewed July 2018. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/hai/cusp/modules/understand/index.html>

3- Deutsch ES, Van CM, Mossburg SE. Resilient Healthcare and the Safety-I and Safety-II Frameworks. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2022.

4- Section 1: Overview of Key Concepts and Tools. Content last reviewed July 2023. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/teamsteps-program/curriculum/intro/overview.html>



# Affinity Group Activities



- Who is invested in this work?
- What competencies in use include safety content?
- What successes and gaps have been identified?
- Who are the target audiences?
- Where is there overlap, and where are there differences?

# Environmental Scan: Key Information Sources

Source	Resource
Accreditation Council for Graduate Medical Education [ACGME]	<ul style="list-style-type: none"> <li>- Common Program Requirements for Residents Section VI: The Learning and Working Environment</li> <li>- Clinical Learning Environment Review (CLER) Pathways to Excellence v. 3.0</li> </ul>
American Association of Colleges of Nursing [AACN]	Essentials Competency-Based Education Domains and Concepts
American Association of Medical Colleges [AAMC]	Quality Improvement and Patient Safety Competencies Across the Learning Continuum (2019)
American College of Healthcare Executives [ACHE]	Healthcare Executive 2024 Competencies Assessment Tool
Canadian Patient Safety Institute [CPSI]	The Safety Competencies: Enhancing Patient Safety Across the Health Professions, 2nd Edition
Institute for Healthcare Improvement [IHI] and Certification Board for Professionals in Patient Safety [CBPPS]	<ul style="list-style-type: none"> <li>- Certified Professional in Patient Safety Exam Content Outline (2024)</li> <li>- Open School Quality and Safety Curriculum: QI 100-200, PS 100-200</li> </ul>
Interprofessional Education Collaborative [IPEC]	IPEC Core Competencies for Interprofessional Collaborative Practices, v. 3
National Academy of Science (prev. IOM) Committee on Health Professions Education	Core Competencies Needed for Health Care Professionals
National Association for Healthcare Quality [NAHQ]	Workforce Competencies for Healthcare Quality Professionals
Quality and Safety Education for Nurses [QSEN]	Quality and Safety Education for Nurses Institute Competencies, Prelicensure
Society of Hospital Medicine [SHM]	Core Competencies in Hospital Medicine, Patient Safety and Quality Improvement
Veterans Health Administration [VHA] National Center for Patient Safety [NCPS]	NCPS Clinical Team Training
World Health Organization [WHO]	Core Competencies for Patient Safety Research

# Safety Science Competency Domains



- 12 competency domains
- Domains include safety themes and supporting themes
- Themes are based on existing competencies that include safety content

# Competency Domains 1-5

Domain Title	Included Knowledge Themes
<b>Leadership, Governance, and Culture</b>	<ul style="list-style-type: none"> <li>• Leadership and Governance for Safety</li> <li>• Shared Vision for Safety</li> <li>• Just Culture/Culture of Learning and Safety</li> <li>• Teamwork and Teaming Behaviors</li> <li>• Ethics</li> <li>• Psychological Safety</li> <li>• Transparency</li> </ul>
<b>Tools for Improvement and Implementation</b>	<ul style="list-style-type: none"> <li>• Quality Improvement Methodologies and Tools</li> <li>• Change Management</li> <li>• Research to Practice</li> <li>• Implementation Science</li> </ul>
<b>Patient Engagement</b>	<ul style="list-style-type: none"> <li>• Patient/Family Engagement</li> <li>• Shared Decision-making</li> <li>• Patient-Centered Care</li> </ul>
<b>Evidence-Based Practice</b>	<ul style="list-style-type: none"> <li>• Evidence-Based Practices</li> <li>• Safe Clinical Practices (Team and Individual)</li> </ul>
<b>Communication</b>	<ul style="list-style-type: none"> <li>• Communication Processes</li> <li>• Care Transitions/Handoff</li> </ul>

# Competency Domains 6-9

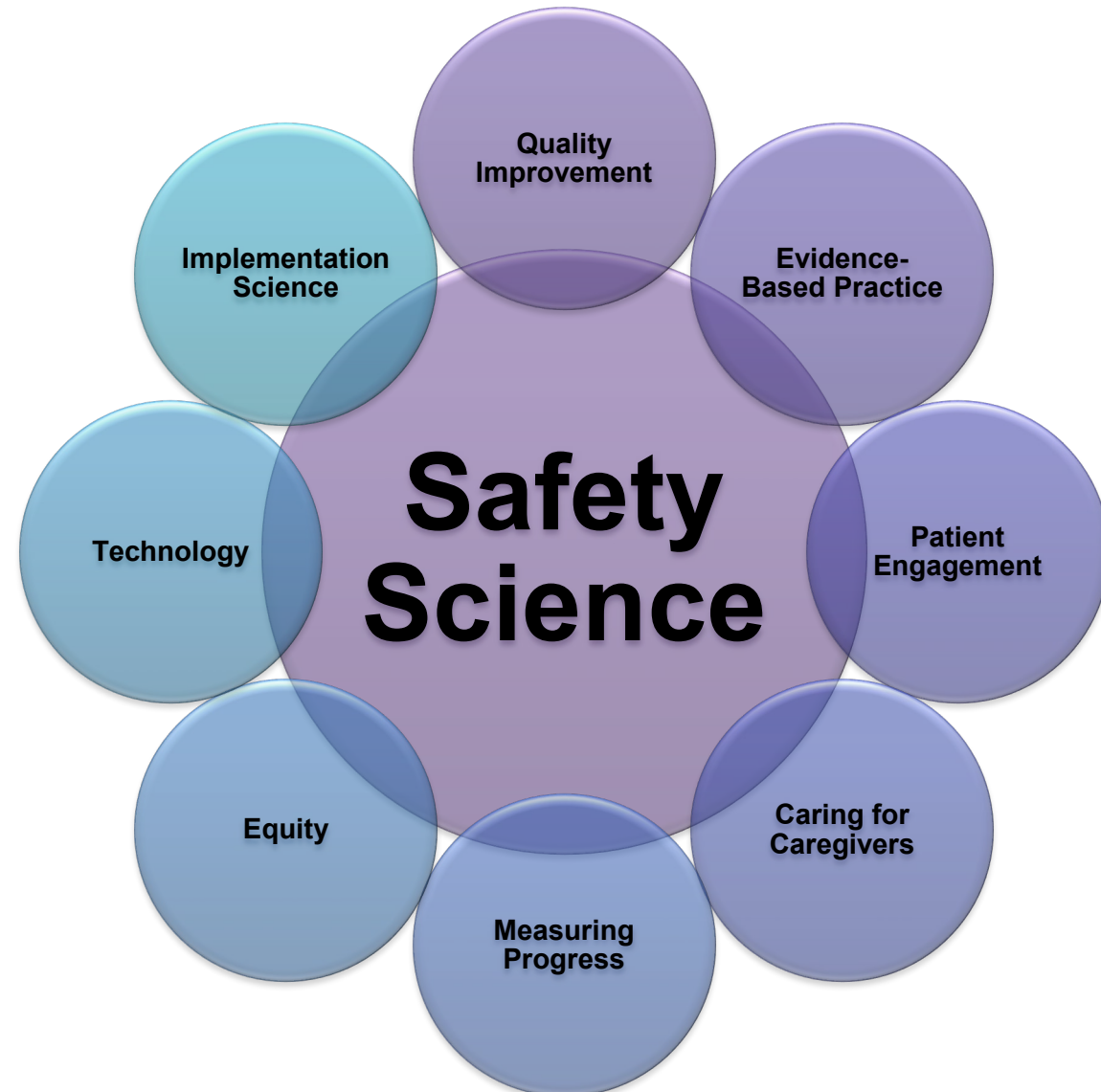
Domain Title	Included Knowledge Themes
<b>Detecting, Reporting, and Responding to Safety Risks and Events</b>	<ul style="list-style-type: none"> <li>• Identifying and Mitigating Safety Risks</li> <li>• Safety Reporting</li> <li>• Responding to Safety Events- Immediate Actions and Longer-Term/Systemic Follow-up</li> <li>• Disclosure</li> </ul>
<b>Measuring Progress</b>	<ul style="list-style-type: none"> <li>• Measurement</li> <li>• Leveraging Data and Analytics to Improve Safety</li> <li>• Create a Business Case for Safety</li> </ul>
<b>Human Factors</b>	<ul style="list-style-type: none"> <li>• Human Factors Engineering (Safe Design Principles)</li> <li>• Types of Human Error</li> <li>• Situational Awareness</li> </ul>
<b>High Reliability and Systems Thinking</b>	<ul style="list-style-type: none"> <li>• Systems Thinking</li> <li>• High Reliability</li> <li>• Standardization</li> </ul>

# Competency Domains 10-12

Domain Title	Included Knowledge Themes
<b>Caring for Caregivers</b>	<ul style="list-style-type: none"><li>• Workload Management</li><li>• Burnout</li><li>• Worker Safety</li><li>• Fatigue</li><li>• Moral Injury</li><li>• Patient Safety/Worker Safety Relationship and Continuum</li><li>• Post Harm Incident-Care for Providers</li></ul>
<b>Technology</b>	<ul style="list-style-type: none"><li>• Safe Use of Technology and Informatics</li><li>• Leveraging Technology for Patient Safety</li></ul>
<b>Equity</b>	<ul style="list-style-type: none"><li>• Equity</li><li>• Disparities in Care</li><li>• Bias</li></ul>

# Supporting Safety Science

- Using our shared understanding of what Safety Science is, we see that our competency domains include both **safety science** and **value-enabling competencies** needed to support it
- The environmental scan revealed different knowledge areas and skills included in safety-related competencies



# Domains Identified Across Safety Competencies





# Affinity Group Activities

## Environmental Scan

- Who is already invested in this work?
- What competencies are already in use that include safety science content?
- What successes and gaps have been identified?
- Who are the target audiences?
- Where is there overlap, and where are there differences?

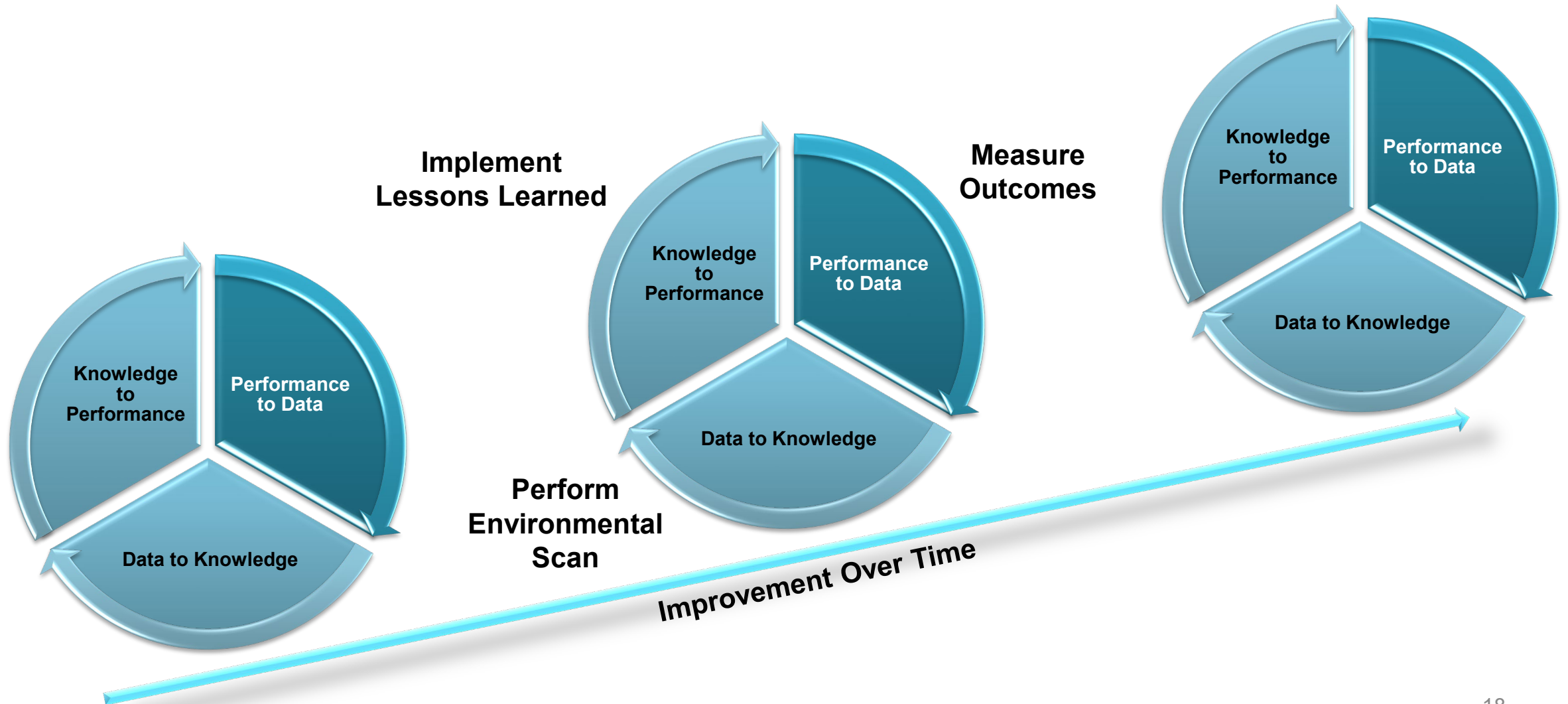
## Competency Domain Identification

- 12 competency domains aggregated from themes identified in existing competencies that include safety science content
- Domains include safety science themes and supporting themes
- Domains can be used as a framework for understanding current competency priorities

## **Current State:** Group Learning and Resources

- Identify gaps in the quality and/or consistency of competency implementation
- Form implementation strategy for uptake of evidence-based competencies
- Provide a resource library on the AHRQ NAA website

# Creating Learning Health Systems



# Speaker Welcome



**Lillee Gelinas, DNP, RN, CPPS, FNAP, FAAN**

Assistant Professor, Medical Education & Health Systems Science  
Patient Safety Section Director, Texas College of Osteopathic Medicine

# Empowering Frontline Staff with Competencies for Patient Safety

**CPPS**

CERTIFIED  
PROFESSIONAL  
IN PATIENT SAFETY

# For Success: Leadership Support Essential



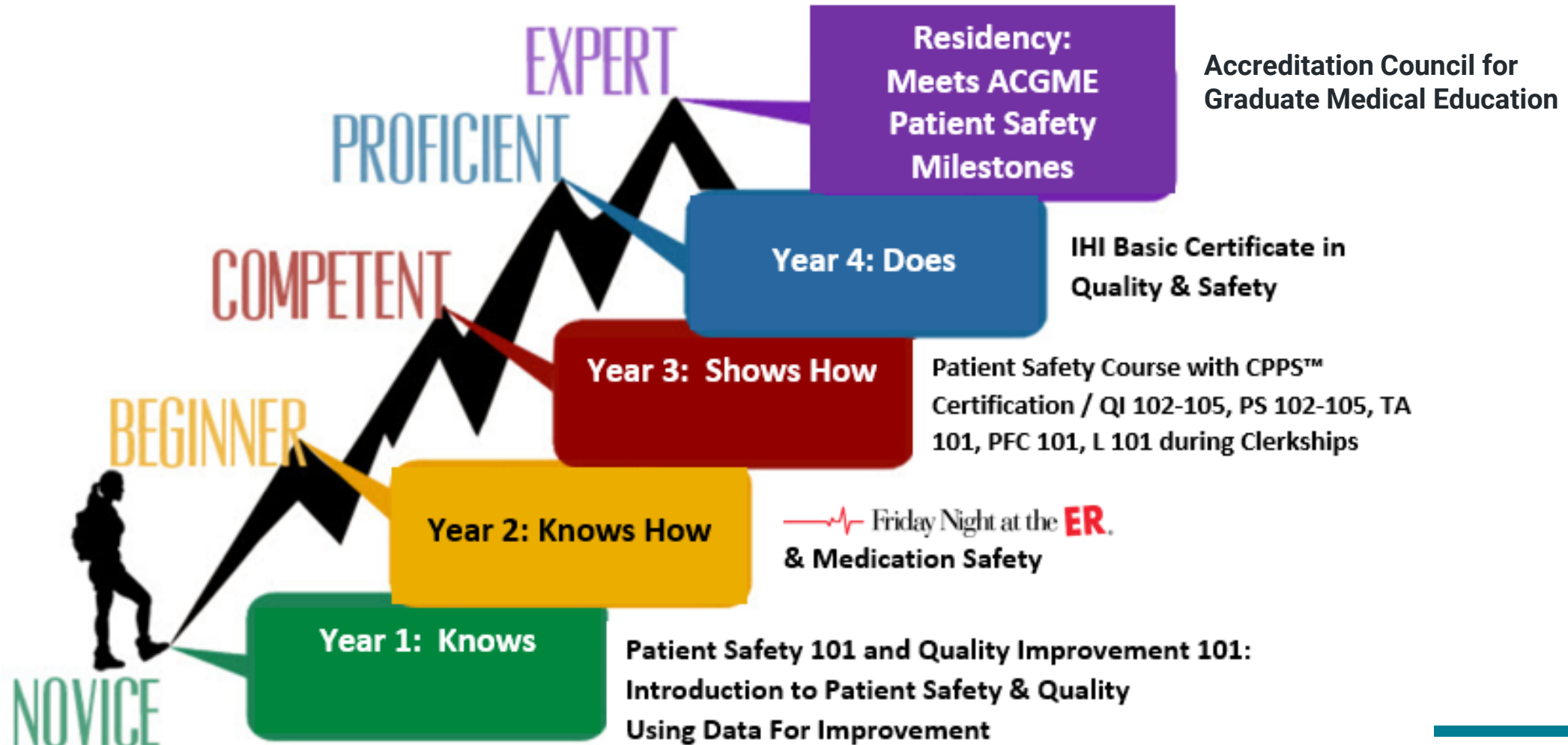
**Michael R. Williams, DO, MD, MBA**  
Chancellor  
University of North Texas System  
Specialty: Anesthesia



**Frank A. Filipetto DO, CPPS, FACOFP**  
Everett Endowed Professor and Dean  
Texas College of Osteopathic Medicine

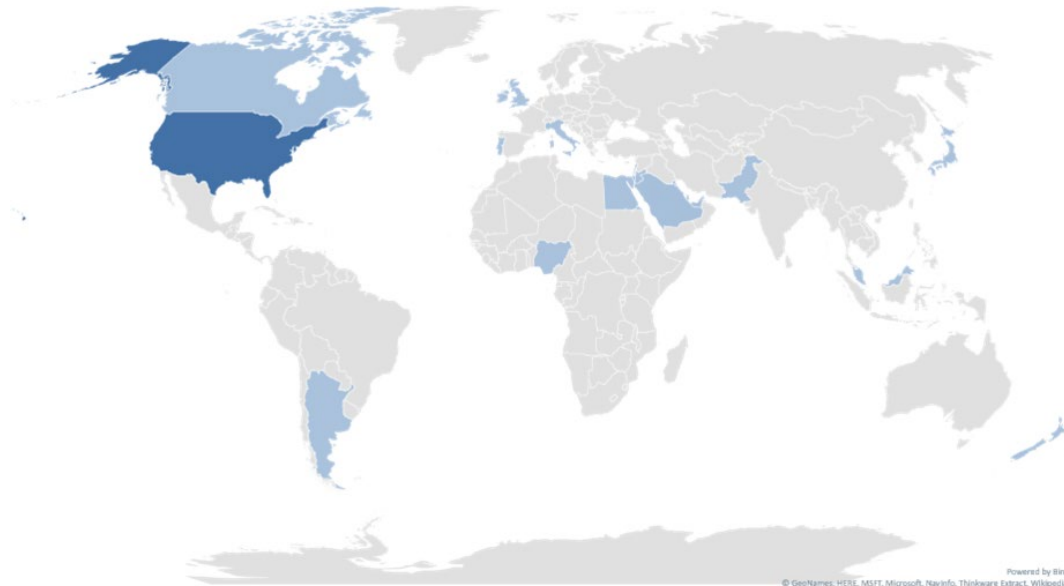
**A H O-Yurvati DO, PhD, CPPS, FACOS, FICS, FAHA**  
Professor and Chair, Medical Education and Health Systems Science  
Texas College of Osteopathic Medicine  
Dallas Southwest Osteopathic Physicians Professor of Surgery  
Professor Institute for Cardiovascular and Metabolic Disease  
Visiting Professor University of Strathclyde- Glasgow Scotland  
Director, Medical Education/Asst. Designated Institutional Official –  
Medical City Fort Worth

# Patient Safety Competency Progression Across 4 Years





# CPPS™ Around the World: An Internationally Recognized, Interprofessional Credential



# The Certified Professional in Patient Safety (CPPS™) Credential



- **Rigorous and comprehensive credentialing process that attests to patient safety competencies and expertise**
- **Evidence-based examination measures competencies in five patient safety domains**
  - 1. Culture**
  - 2. Leadership**
  - 3. Patient Safety Risks and Solutions**
  - 4. Measuring and Improving Performance**
  - 5. Systems Thinking and Design / Human Factors Analysis**



# Culture Domain Competencies/Skills – Examples

- **Raising awareness**
  - Engage healthcare team in patient safety initiatives
- **Promote a culture of safety**
  - Articulate principles and science of patient safety in initiatives
  - Address patient safety implications associated with operational changes, such as cost-reduction measures
- **Ensure involvement of patients and caregivers in patients' healthcare decisions**
- **Articulate and apply principles of a fair and just culture**

# Patient Safety Course Structure and Key Collaborators

- **Mandatory Course for all 3<sup>rd</sup> Year students**
- **Synchronous Classes (via ZOOM, 4 hours) + Asynchronous Learning**
- **Course length: 9 weekdays + 1 exam day**
- **38 hours – class time (ZOOM)**
- **36+ hours – self-directed study to complete the *CPPS Review Course* modules on the IHI Learning Management System and reference materials on UNT's CANVAS System**
- **Students complete all academic requirements to sit for the CPPS™ Certification Exam**
- **Use of *Microsoft Forms* + In-class Quizzes:**
  - **202 Comprehension Check and Practice Questions**
  - **All students equally engaged, all students participate 100%**



# Alignment with Surgery Rotations



<https://www.aorn.org/outpatient-surgery/article/the-big-three-wrong-site-specialties>

Outpatient  
**Surgery**  
Magazine  
A Division of AORN

**orthopedics, neurosurgery, urology**

< All Articles

**The Big Three Wrong-Site Specialties**

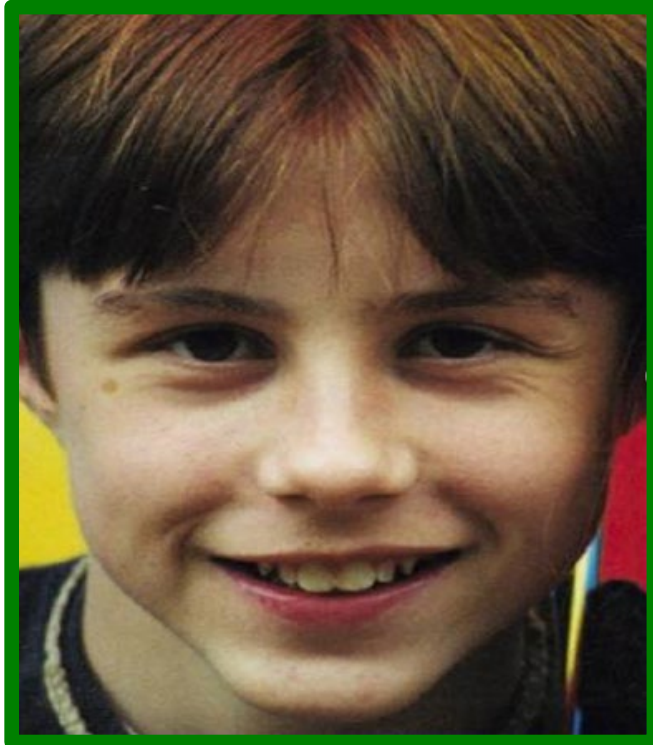
Breaking News

By: Adam Taylor

Published: 6/15/2023



# Course Content Ties To



Lewis Blackman  
1985-2000

**Accreditation Council on  
Graduate Medical Education  
Core Competencies  
(Milestones)**

**Name System Issues that  
Contributed to Patient Death**



**Systems-Based Practice 1: Patient Safety and Quality Improvement**

**Competency Levels**

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Mentors others in the disclosure of patient safety events
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., infection rate, hand hygiene, opioid use)	Participates in local quality improvement initiatives	Demonstrates the skills required to identify, develop, implement, and analyze a quality improvement project	Creates, implements, and assesses quality improvement initiatives at the institutional or community level

**Comments:**

Not Yet Completed Level 1

# Outcomes to Date – Quantitative (Data)

- **965 Students Completed the Patient Safety Course as of July 20, 2024:**
  - CPPS™ Certification Exam Pass Rate**
    - 4<sup>th</sup> year students (26) – 100% pass rate
    - 3<sup>rd</sup> year students - 94% first time pass rate
    - International Pass Rate, All Professions = 70%**
  - **98% of TCOM Students Graduate with the CPPS™ Credential**
- **27 Faculty Completed the Course & Passed the Certification Exam – TCOM Leadership, Clerkship Directors and Other Faculty**
- **Pre Test (Session 1) / Post Test (Session 9): Students are improving knowledge across all 5 Patient Safety domains**

# Outcomes to Date – Qualitative (Stories)

- "Overall, I learned a lot about teamwork, leadership, and patient safety. I feel I will be a more well-rounded physician because of this course."
- "I learned a lot about issues and ways that I can contribute as an individual to hopefully prevent these errors in my future practice."
- "An important lesson from this course is how a well-run organization is supposed to work and what to look out for in organizations that I work for, send my friends/family to, or interact with in the future."
- TCOM 4<sup>th</sup> Year Medical Student finished suturing a hand in the ED: Recognized inadequate irrigation  
<https://www.ihi.org/insights/learning-patient-safety-culture-turning-fog-concrete>

# Key Messages

- **To change the way healthcare is delivered to ensure safe, quality care, embed patient safety education into all medical and health professions curriculum and practice settings**
- **Don't reinvent the wheel! Utilize proven strategies, resources, collaborators and best practices to create your own program**
- **To support the practice of accountable professionals, demonstrating safety proficiency and skills, support Patient Safety Certification in your organization**



# Question & Answers

# Upcoming Events of Interest



## **AHRQ Seeks Nursing Homes for Pilot Test of Surveys on Patient Safety Culture Nursing Home Survey 2.0**

AHRQ seeks nursing homes to participate in a pilot test of an update to the Surveys on Patient Safety Culture® (SOPS®) Nursing Home Survey (Version 2.0) with supplemental items assessing staff workplace safety. The 2.0 survey is shorter than the current 1.0 survey and includes revised and new items based on user feedback.

Participating nursing homes will receive:

- Up to \$1,000: \$500 for participation, and an additional \$500 for sites that achieve at least a 50 percent response rate.
- Free survey administration to nursing home staff of the 2.0 survey with workplace safety supplemental items in Aug./Sept. 2024.
- Feedback reports comparing their results to other pilot sites.

To express interest in participating, or to learn more, email [NursingHomeSurvey@westat.com](mailto:NursingHomeSurvey@westat.com).

# Let us know!

Based on what you have learned today, which safety competencies would you most like to develop or reinforce in your organization to prevent harm?

**\*Please submit your response in the chat**

# Thank You!

Announcing the Next NAA Monthly National Webinar  
**Advancing Patient Safety Through Diagnostic Excellence**  
**September 17, 2024**  
**Noon- 1:00 PM ET**

Registration is open and can be found on the NAA website  
<https://cma.ahrq.gov/actionallianceseptember>

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