

**Facilitator's Guide:**  
**Quality and Safety Educators Academy**

Session: Patient Safety  
Time: 1 hour and 45 minutes

Goal: Provide attendees with a framework and set of tools for thinking about medical errors and near miss patient safety events

Specific Learning Objectives:

- 1) Define key terms commonly used in patient safety work (AT and JM)
- 2) Practice using root cause analysis skills to identify and categorize contributing factors to medical error (AT)
- 3) Correctly categorize strong versus weak action plans in response to root cause analyses. (AT)
- 4) Compare and contrast systems errors from cognitive errors and describe how both can be taught using similar patient safety tools (JM)
- 5) Discuss strategies for managing challenges that arise when discussing and teaching residents about safety and error

Methods: 1) Case-based didactic teaching to illustrate key concepts  
2) Hands-on practice using a contributing factors worksheet and fishbone diagram to teach root cause analysis skills  
3) if we decide to weave in the resident reaction/emotion stuff, we could have people do a go-round talking about their experiences here.

Toolkit Items: 1) Journal articles on patient safety, RCA, cognitive errors  
2) Copy of the completed cases with contributing factors worksheet and cognitive-systems fishbone diagram that we used in the talk

Flow of Session:

Present Case and use to illustrate definitions & error analysis 20 minutes - AT  
Use Case to illustrate Hierarchy of safety intervention concepts 10 min – AT  
Table Breakout #1: propose action plans with report out – 15 min AT  
New Case to illustrate difference btwn cognitive and systems error 15 min – JM  
Table Breakout #2: work through a cognitive-systems fishbone 15 min - JM  
The elephant in the room: Personal stories of resident-error related scenarios that arise in medical education 10 min- AT/JM  
Final Breakout vs Large Group Q&A on Resident Challenges in Safety 5-10 min – AT/JM

# DIAGNOSTIC ERROR FISHBONE DIAGRAM

