Healthcare Organization Commitment

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APSS

Have you reviewed the Patient Safety Movement Foundation's Actionable Patient Safety Solutions (APSS)?
Yes

What Patient Safety Challenge does your Commitment address?
Commitment Summary
The World Health Organization defines patient safety as the prevention of errors and adverse effects to patients associated with health care. Medication errors are the third leading cause of death in the United States. Pharmacists are the guardians against drug misadventures and medications that could cause patient harm. Medications are also patient’s most frequently encountered form of medical therapy. Pharmacists are the most frequently encountered and accessible care giver in health care as a result. There is a pharmacy and pharmacists within five miles of every American citizen. Pharmacists are in our community and are underutilized resources that can be leveraged to keep patients safe in health care. To decrease morbidity and mortality associated with adverse health care events and medication errors, we have identified pharmacy students as a target group to introduce the full range of concepts in the patient safety curriculum and the PSMF actionable Patient Safety Solutions. Beginning with the first year of their professional education, patient safety concepts, the patients voice, and the concept of preventable harm and death are introduced with the goal of building on this foundation throughout their education and training that will lead to the development of entry-level practitioners with a broad knowledge base and skills that can be used to improve patient safety. Not the least of which a safety-oriented culture and practice orientation. The key stakeholders that will be involved in our commitment to develop and implement patient safety initiatives include CUSP faculty, our schools’ staff, clinicians, and health care systems partners. Our school’s five-year strategic plan calls for specific activity and investment in patient safety research, education and practice. These graduates will be part of the future workforce of health care professionals steeped in patient safety, focused on improving patient outcomes, and elimination of preventable error harm and mortality. They will be high performing team players capable of meeting the demands of the complex environments at their respective practices.

Action Plan
3. Human Factors: This domain is very important to address since it resonates with the textbook “To Err Is Human” where almost all of the medical and medication errors stem from human factors. In order to deliver safe care to patients, our students need to know and understand how people perform under different circumstances and the different types of human-to-human interactions such as communication, teamwork and organizational culture. Our curriculum will incorporate examples from the aviation, military and manufacturing sectors to reinforce how teamwork and human factors are essential to improve their services.
and ensure their success. Students will learn how human factors can be used to reduce/prevent adverse events and medication errors, identify how and why systems break down, and understand why mistakes are made. 5. Teamwork & Communication: Teamwork and effective communication are pivotal in any successful organization. In terms of the patient safety curriculum, students will learn about the benefits of interprofessional teams and how they can improve patient care and reduce medical/medication errors. Students will learn that team members are comprised of health care practitioners, the patient and/or patient’s family, and other relevant ancillary members. Furthermore, the students will learn that effective health care teams are successful when they communicate with one another, engage in shared decision-making, and practice professional responsibilities to optimize patient outcomes and care. 7. Culture of Safety: In order to ensure safety when providing medication therapy management and comprehensive health services to patients, we plan to incorporate non-punitive safety culture principles and real-life case scenarios that will emphasize the appropriate, effective reporting mechanisms to help prevent and correct system failures and human errors rather than seeking individual or institutional culpability. As part of the process of educating pharmacy students about a blame-free culture, they will learn how to (1) work collaboratively in interprofessional health care teams, (2) recognize and/or identify unsafe situations and practices, (3) take preventive action to avoid unnecessary risks, and (4) implement the culture of safety at their experiential rotations and in their future workplaces. 8. Patient-Oriented Safe Care: This domain will be implemented in our curriculum by underscoring the importance of appropriate, effective communication through core courses and extracurricular activities. Examples of the activities will include real-life exercises of communication hand-offs, clearly defined roles and responsibilities within an interprofessional health care team, and active engagement with patients to understand their needs and respect their expectations and fears. -- 3. Human Factors • Implement in Objective Structured Clinical Examinations (OSCEs) and Interprofessional Education (IPEs), Pharmacist Care Skills Labs (PCL) • Simulations • Didactic courses 5. Teamwork & Communication • Continue to reinforce in the Health Care Communication and PCL courses • Implement this in OSCEs and IPEs • Explore opportunities to have students practice these skills in IPPE and APPE settings • Extracurricular and co-curricular activities with other professional students 7. Culture of Safety • Weave this concept in pre-existing courses via TBL activity, lecture, and case studies • Emphasize in OSCEs and IPEs • Emphasize in IPPEs and APPEs 8. Patient-Oriented Safe Care • Continue to reinforce in the Health Care Communication and PCL courses • Emphasize in OSCEs and IPEs • Explore opportunities to have students practice these skills in IPPE and APPE settings • Extracurricular and co-curricular activities