CURRICULUM EVALUATION TOOL

Finnish Centre for
Client and Patient Safety

INTRODUCTION

This tool is intended for the evaluation of the education curricula and study unit descriptions of the social welfare and healthcare sectors. The evaluation is focused on the education of client and patient safety.

Participants to the tool's development work have included specialists from the Finnish Centre for Client and Patient Safety, specialists of the social welfare and healthcare sectors from wellbeing services counties and from various educational institutions.

The contents are based on the WHO's *Multi-professional Patient Safety Curriculum Guide, 2011*. The tool was created based on the content recommended by the WHO, applying them to the Finnish context while taking into account the changes in the social welfare and healthcare operating environment. The topics added to the tool are the safety of devices and equipment, and the safety of the operating environment.

EXPERTISE IN CLIENT AND PATIENT SAFETY IS PART OF THE BASIC KNOWLEDGE AND SKILLS FOR SOCIAL WELFARE AND HEALTHCARE PROFESSIONALS

The expertise of social welfare and healthcare professionals is essential when seeking to prevent mistakes and harm in services and care. Client and patient safety expertise must systematically be promoted in basic education and maintained in further and supplementary education.

The purpose of this tool is to help parties providing education in their work on planning curricula, planning the goals and contents of study units and examining implemented curricula and study units.

During the development work, the tool was tested at the Oulu University of Applied Sciences' degree programmes for Nursing and Health Care, Preventive Health Care, Midwifery and Social Services. The teachers found that client and patient safety is integrated into many different study units in the programmes. It was also found that client and patient safety was promoted well with very diverse learning methods, such as lectures, videos, workshops, role play, simulations and gamification. Guided practice also plays an important role in the learning of client and patient safety.

Teachers found the evaluation of curricula and study unit descriptions eye-opening. They felt that the structure and content of the tool help educators in their work on curricula and the development work of study units. The tool helps teachers understand the scope of client and patient safety. It also helps identify the core and foundation for teaching the knowledge, skills, attitudes and culture related to safety training for each professional field. Another important observation was that there is a need for collaboration between the various degree programmes. Client and patient safety is everyone's shared goal.

CONTENTS OF THE TOOL

In the tool, client and patient safety has been broken down into **13 learning topics**. They are based on the WHO's patient safety curriculum structure applied to the Finnish operating environment.

Figure 1. Learning topics of client and patient safety (adapted from WHO 2011)

USE OF THE TOOL

The evaluator examines the curriculum of the programme to be assessed, as well as the descriptions of all its study units. They must examine the 13 topics presented in this document one at a time and evaluate whether the topics and their concepts, goals and contents are included in the learning outcomes and content of the programme's study units. An Excel sheet can be used to support the evaluation.

Each of the 13 topics has sections for content and learning outcomes. The **CONTENT** section describes the theoretical content of the topic, while the **LEARNING OUTCOMES** section includes more practical issues related to each topic. In topics 1, 3, 12 and 13, content and learning outcomes are presented as one section.

When all the programme's study units have been examined for each topic, the evaluator can make an overall evaluation regarding the curriculum's client and patient safety. The topic contents have been planned so that they might cover the full scope of client and patient safety in the social welfare and healthcare sectors as comprehensively as possible.

Evaluators should apply the tool to the curriculum and study units to be examined by selecting content within the topics that is essential to the programme in question. The tool can be modified to suit the needs of each degree programme.

TOPIC 1

WHAT IS CLIENT AND PATIENT SAFETY?

CONTENT AND LEARNING OUTCOMES

Definition of patient safety

Definition of client safety

Terms and concepts of client and patient safety

Patient safety from the perspective of patients, friends and family, patient-oriented approach

Client safety in the social welfare sector and in rehabilitation, client-oriented approach

History of patient safety and development into its current state

- blaming, blame culture
- impacts of blaming if the focus is on individuals instead of systems
- systems theory, systemic errors

Patient safety work relative to quality work

- patient safety procedures

What can we learn from other fields?

Evidence-based treatment

Professional ethics

Organisation of safety work

RESPONSIBILITIES AND OBLIGATIONS IN CLIENT AND PATIENT SAFETY

Laws, decrees and regulations

Client and patient safety strategy

Self-monitoring programme

Self-monitoring plan

TOPIC 2

HUMAN FACTORS

Why is it important to take human factors into account for safety?

How do the physical, psychosocial and digital work environments affect a person's ability to work safely?

How do stress and fatigue affect a person's assessments, decision-making and performance?

CONTENT

ONBOARDING

Overall onboarding, safety onboarding

Recognising the limits of competences

PERSONNEL WELLBEING

Human performance

Ergonomics

- physical
- organisational

ETHICAL PRINCIPLES

Ethical stress

PSYCHOLOGICAL SAFETY

Employee's wellbeing and capacity after harmful incident or near miss

Debriefing procedures, Second Victim protocol

LEARNING OUTCOME

OPERATING METHODS AND ATTITUDES

- professional
- ethical

SAFETY CULTURE

Organisational and individual operating culture

Client and patient safety culture

- clients, patients and next of kin as contributors to the safety culture

Personal values and beliefs, including unconscious ones

Continuous learning and feedback

Learning from own mistakes and the mistakes of others

Constructive discussion atmosphere, ability to discuss problems

- quality of care or client/patient safety
- bullying, harassment or disparagement (how to intervene? how to prevent?)

WELLBEING AT WORK

- work management
- coping (recognising the limits of coping ability)
- taking care of your own wellbeing
- risks to work ability and safety related to your own health
- stress management skills

RESOURCES AND FUNDING

- sufficient personnel and resources as a safety factor

TOPIC 3

UNDERSTANDING SYSTEMS AND THE SAFETY IMPACT OF COMPLEXITY

How can systems thinking improve social welfare and healthcare, as well as minimise harmful events?

CONTENT AND LEARNING OUTCOMES

System, complex system, reliable organisation

- high reliability organisation (*HRO*)

Monitoring, measurement, evaluation

Event, event monitoring

The role of systemic errors (organisation-level errors) in ensuring safety

Risks, risk awareness and risk management

- clinical risk, risk assessment

Social welfare and healthcare risks due to complex processes and multi-professional work

TOPIC 4

TEAMWORK

What is good teamwork, and how does it affect client and patient safety?

CONTENT

SAFE TEAMWORK AND SAFE COMMUNICATION

Team, roles, responsibilities, leadership, values, assumptions, communication, listening skills, learning styles, conflict resolution

WORKPLACE COMMUNITY SKILLS AND TEAMWORK

Multidisciplinary and multi-professional approaches

Multi-professional and consistent competences in client and patient safety

The roles of specialised fields and other healthcare and social welfare professionals, and respecting their expertise and professional skills

Being an effective team player

The responsibilities and obligations of teamwork

Prioritisation and decision-making in a team

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Multiple casualty incidents and major accidents

Organisational learning

LEARNING OUTCOME

Note that you are a member of multiple teams.

CLEAR COMMUNICATION

- Safe, clear and appropriate transfer of data
  - speech
  - writing
  - electronic communication

- Ensuring the continuity of care when transferring the burden of care from one party to another
  - upon change of shift or ward
  - data transfer between systems

- Reporting and ISBAR
  - Identify
  - Situation
  - Background
  - Assessment
  - Recommendation

Collegiality, working in the best interests of the client/patient

Intervening in unprofessional work

Characteristics of a successful team

CRM - Crew Resource Management

TOPIC 5

LEARNING FROM SAFETY EVENTS TO PREVENT FURTHER EVENTS

How can we learn from mistakes in social welfare and healthcare and improve safety?

CONTENT

Understanding the nature of a mistake

Mistake, abnormality, near miss, deviation

Oversights and lapses caused by a lack of competence versus mistakes

Situations linked with an increased risk of mistakes

Root cause analysis

Quality deviations

Appeals

Objections and complaints

SAFETY EVENT REPORTS AND DEVELOPING OPERATIONS BASED ON REPORTS

Reporting mistakes and near misses

Reporting safety events and harmful events, reporting systems

Hotline indicators (Never Events)

Open and honest discussion of mistakes with clients/patients, healthcare professionals and supervisors

Learning from mistakes

LEARNING OUTCOME

REPORTS

Filing a report

Processing

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Medication safety

Device safety

Deficiency report

Notification of concern

Statutory reporting obligations and rights

THE REPORTING OBLIGATIONS OF PROFESSIONALS INCLUDE

- child welfare notification
- report regarding suspicion of crime against a child
- social care support need
- service need for an older person
- reporting obligation regarding a deficiency in the implementation of social care
- separate reporting obligation for doctors regarding diminished driving health
- reporting obligation for healthcare professionals regarding a threat to traffic safety
- obligation to report a risk of fire or accident
- reporting obligation for doctors and dentists regarding infectious diseases

THE REPORTING RIGHTS OF PROFESSIONALS INCLUDE

- reporting activities endangering patient and client safety
- use of intoxicants affecting driving health
- state of health of a holder or applicant of a passenger transport licence
- diagnosed or suspected adverse effects related to use of medication
- diagnosed or suspected adverse effects of vaccinations

TOPIC 6

RISK MANAGEMENT

How are the principles of risk management applied to identify, assess and report deviations and potential workplace risks?

CONTENT

Clinical risk, risk assessment, event, event monitoring, reporting of near misses

IDENTIFY, INVESTIGATE AND LEARN

Risk identification and reporting

Use of indicators

Experiences, views and complaints of patients and their friends and family

Patient safety II, learning from what goes right

LEARNING OUTCOME

ASSESSMENT AND MONITORING OF PATIENT SAFETY

Logging, documenting, structured logging

Improving safety culture

The utilisation of risk management principles to identify and assess hazardous situations and potential risks at the workplace, e.g. the role of complaints in developing safety and care.

RISK AREAS, MEDICAL ERRORS AND SPECIAL SITUATIONS

Identification of situations and circumstances with an elevated risk of harm to patients or clients, and the management of such risks

Prevention of falls and bed sores, risk inspection

Suicides during treatment period

Prevention of infections related to treatment

Resources and funding: sufficient personnel and resources as a safety factor

Radiation safety

High-risk medication

Accessibility checklist

REPORTING AND PROCESSING SERIOUS SAFETY EVENTS

PREPAREDNESS AND PATIENT SAFETY

Emergencies and exceptional situations

Prevention, risk identification and management of threatening and dangerous situations

Analysis of the progression of a dangerous situation with root cause analysis tools

Crises and catastrophes: accidents, chemical/biological risks in radiation or nuclear accidents

Normal situation versus Raised preparedness versus Catastrophe scenario

- plans and principles
- plans for exceptional circumstances
- catastrophe drills

TOPIC 7

CONTINUOUS IMPROVEMENT OF QUALITY

CONTENT

Quality work, analysis, reporting

Quality improvement methods in improvement of services

Evidence-based action

Service quality and patient/client satisfaction

SYSTEMS THINKING, THEORY AND FRAMEWORK

Systems thinking, systemic error

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View on patient safety over time

- before and now
- individual and system

Safety in a complex (adapting) system

Process thinking

- integrating safety in processes, decision-making and organisational structures
- quality of treatment, care and services from the perspective of processes

High reliability organisation (HRO)

MANAGEMENT, GUIDANCE AND LEADERSHIP OF SAFE TREATMENT

Safety management system

Management system for differing circumstances

Reliable and safe work environment

Processing and communicating about risks and mistakes

Support for employees

Quality management principles and application

Significance of quality registers and treatment outcome benchmarking

LEARNING OUTCOME

Quality improvement

PDSA cycle

Terms and concepts related to change

Variation

Quality improvement methods

Quality improvement tools

Flowcharts

Cause-and-effect diagrams (Ishikawa/fishbone diagrams), Pareto charts, histograms, operation diagrams

SAFE PROCESSES AND WORKING METHODS

Understanding the organisation, processes and working methods in a complex system

Implementing processes, methods and working methods

Safe data transfer and continuity within a ward and between wards

Care pathways and digital care chains – client/patient-oriented approach

Electronic client and patient data systems (functionality)

Continuous learning

TOPIC 8

ENGAGEMENT OF PATIENTS, CLIENTS, FRIENDS AND FAMILY

CONTENT

CLIENT AND PATIENT SAFETY TOGETHER WITH CLIENTS/PATIENTS AND THEIR FRIENDS AND FAMILY

Client/patient-orientedness

Informed decision-making

Including clients/patients and their friends and family in the care and care planning at all stages of care

Providing information regarding alternatives to examinations and treatments as well as likely benefits and possible negative impacts so that clients/patients can make justified decisions on their care

Including clients/patients and their friends and family in systematic client and patient safety work

EQUALITY, EQUITY, NON-DISCRIMINATION

Health differences, social and socio-economic background factors, risks caused by work or living environment

- effects on the course of diseases and success of treatments
- mitigation of effects

Age, gender, language

Poverty, homelessness, marginalisation.

IMMIGRANTS/MULTICULTURALISM

Culture-specific issues, cultural norms, understanding the principles of society

Refusing treatment – e.g. cultural/religious differences, information-based decision-making

Professional attitude towards procedures performed for non-medical reasons, e.g. (female) genital mutilation

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Differing mother languages and cultural backgrounds between client/patient and professional, need for interpreting

Plain language

VULNERABLE CLIENT GROUPS

Life situations of clients and patients in vulnerable positions and working with them

Empowering clients/patients, partnership

Groups with special support needs

- people with dementia
- mental health and intoxicant abuse customers
- people with developmental disabilities

Effects of harmful addiction on health, intervening in addiction while supporting the client/patient

Continuity of care

Special questions related to the safety of older clients/patients, such as service pathway, flow of information and societal digitalisation

Children and youths

CLIENT AND PATIENT RIGHTS

Client and patient rights, autonomy and the requirements for restricting autonomy

Preventive operating methods

Advance decision documents – living wills

LEARNING OUTCOME

INTERACTION

Assessing a client/patient's capacity to understand, absorb information and make decisions

Offering explanations, advice and support in a way that reflects the client/patient's level of understanding and needs

Supporting the client/patient's resources

Clarity, efficiency, considering the other party, reliability, considering fear

- listening, responding to questions
- empathy and sympathy
- interaction skills – utilising language and non-verbal communication

- skills to adjust communication individually based on factors such as sensory disabilities or limited language skills
    - impaired hearing, vision or speech production, aphasia
    - reduced cognitive capacity or learning ability
    - plain language

Clear use of speech, writing and electronic communications that takes the receiving party into account (including in medical reports) in the following situations:

- conveying bad news to a patient or their friends or family
- conveying news of a death
- sensitive issues: use of alcohol, tobacco, obesity or reproductive health

Skills to assess the client/patient's ability to decide on their care and knowing how to act when the client/patient's ability to make decisions is temporarily or permanently impaired

Respectful and human encounters – including in situations where the client/patient is a risk to themselves or others (psychosis, dementia, alcohol, narcotics, etc.)

HARMFUL EVENTS AND SAFETY EVENTS, COMPLAINTS

Encouragement towards filing reports, support of filing reports

Open discussion, apologies

Recognising abuse, violence and neglect

Appropriate operating methods in the care of persons using intoxicants, engaging in self-harm or under risk of suicide

TOPIC 9

INFECTION PREVENTION AND CONTROL

CONTENT

Infection prevention and control

Infection

Hospital-acquired infection

- cross-infection

Treatment-related infections

- *health care-associated infections (HCAI)*

Microbiology

Antibiotic resistance in microbes

- *antimicrobial resistance* (AMR)

Multidrug-resistant bacteria

- e.g. MRSA = *methicillin-resistant Staphylococcus aureus*

Transmission (infection from one unit to another)

LEARNING OUTCOME

Hand hygiene

Aseptic techniques

- aseptic working methods
- aseptic conscience

Normal precautions

Contact, droplet, airborne and protective precautions

Employee vaccinations

TOPIC 10

PATIENT SAFETY IN INVASIVE PROCEDURES

CONTENT

Surgical safety

Operation room checklist/other checklists

Instructions/guidelines

Onboarding instructions

Teamwork

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Communication

Infections of the site of surgery/procedure, surgical/procedural errors

Confirmation processes

Verification processes

LEARNING OUTCOME

Identification of patient at different stages

Checklists

Surgical team's checklist

- before anaesthesia
- before surgery
- after surgery

Correct use and storage of sharp instruments to prevent incidents such as blood accidents.

SAFE TEAMWORK AND SAFE COMMUNICATION

Ensuring continuity of care when transferring the burden of care from one party to another when changing wards or shifts

Data transfer, including between electronic systems

TOPIC 11

MEDICATION SAFETY

CONTENT

Medication safety

- sales permit procedures, evaluation of efficacy, safety and quality, register of adverse reactions

Medication safety

- Humane work by those administering pharmacological treatment

- Accuracy and efficiency of pharmacological treatment process

Side effects, adverse effects, adverse reactions, abnormalities, errors, harmful events, harmful pharmacological events, medication error, and the prescription, administering and monitoring of medication

Abnormalities

- the most significant risk factor endangering patient safety in healthcare
- a mistake may even lead to death
- something is done wrong or something is not done
- unnoticed interactions and overlap
- providing the patient with the wrong medication
- providing the medication to the wrong patient
- forgetting to provide medication
- abnormality in logging, patient guidance or effect monitoring

LEARNING OUTCOME

Prescription of medication

Distribution of medication

Logging prescriptions and changes to prescriptions

The 10 Cs of pharmacological treatment processes

- correct patient
- correct medication
- correct dosage
- correct time of administration
- correct route of administration
- correct purpose of use
- correct preparation of medication
- correct documentation
- correct guidance
- correct monitoring and evaluation of effects

Safeguards of the pharmacological treatment process (e.g. double check)

Pharmacological treatment plan of the organisation/unit

operating models, selection of medication, ensuring safety, guidelines, etc.

Ensuring pharmacological treatment competences in working life

- medication safety training
- necessary permits and evidence
- fluid therapy guidelines
- blood product guidelines

TOPIC 12

SAFETY OF DEVICES AND TECHNOLOGIES

CONTENT AND LEARNING OUTCOMES

DEVICE SAFETY

Cooperation between humans and technology

Medical devices

Software

Standards and regulations on medical devices

Professional user

Guidance of client/patient in using healthcare and wellbeing technology

Ensuring the functionality and user safety of devices

SAFE USE OF RADIATION

DATA SYSTEMS

DIGITAL TECHNOLOGY

Digital technology, remote consultation

Remote consultation (phone, video, chat)

Remote and digital services – client/patient's right to choose

DATA PROTECTION AND SECURITY IN THE SOCIAL WELFARE AND HEALTHCARE SYSTEMS

Obligation of secrecy and confidentiality

Data protection, data security, information security, confidentiality

Access control

TOPIC 13

SAFETY OF THE OPERATING ENVIRONMENT

CONTENT AND LEARNING OUTCOMES

Safety of facilities

- accessibility
- stairs
- windows
- order of rooms for monitoring
- sharp objects
- (other people)

Chemical safety

Fire safety

Environmental safety

- prevention of infectious diseases

Waste management

- hazardous waste

Work safety – safety plans and procedures for reporting dangerous situations

Employee background checks

SUPPORT MATERIAL FOR USE IN EDUCATION

Training material on all WHO topics (topics 1–11 in the document) is available free of charge through the Finnish Centre for Client and Patient Safety. A PowerPoint presentation and instruction video is available regarding the topics.

Similar material is not yet available for the device safety and operating environment safety topics, which were decided to be added as separate topics to this education evaluation material. The links below provide more information on these topics, as well.

WHO's Patient Safety Curriculum Guide
Multiprofessional Edition
Patient safety curriculum guide: multi-professional edition (who.int)
DIRECT LINK: Who1-17 FirstPages

Global Patient Safety Action Plan 2021-2030
Global Patient Safety Action Plan 2021-2030 (who.int)

National Patient Safety Education Framework
The Australian Council for Safety and Quality in Health Care
National Patient Safety Education Framework (safetyandquality.gov.au)

National Model Clinical Governance Framework
Published by the Australian Commission on Safety and Quality in Health Care
National Model Clinical Governance Framework | Australian Commission on Safety and Quality in Health Care

The Safety Competencies Enhancing Patient Safety Across the Health Professions Second Edition
The Safety Competencies 2ND EDITION Enhancing Patient Safety Across the Health Professions (healthcareexcellence.ca)

Final report
Embedding patient safety in education & training
Netherlands Association of Hospitals, the Society of Medical Specialists, the Netherlands Federation of University Medical Centres, and the Netherlands Association of Nurses & Caregivers
Final-report-embedding-patientsafety-training.pdf (vmszorg.nl)

Curriculum Guidance for Delivering the NHS Patient Safety Syllabus Training in Patient Safety
Curriculum Guidance for Delivering the NHS Patient Safety Syllabus Training in Patient Safety (hee.nhs.uk)

NHS Patient Safety Syllabus
NHS Patient Safety Syllabus.pdf (hee.nhs.uk)

Scottish Patient Safety Programme (SPSP)
Scottish Patient Safety Programme (SPSP) | ihub | Health and social care improvement in Scotland – Scottish Patient Safety Programme (SPSP)