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Improving Patient Safety in Occupational Therapy Practice: Education for Occupational Therapy Practitioners

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Learning Objectives

At the completion of this **1.5 hour workshop** participants will:

Summarize key concepts and principles of patient safety and error prevention and relate these concepts to occupational therapy practice

Critically analyze two vignettes based on actual adverse events in occupational therapy practice to determine the impact on patients, families and practitioners.

Relate analysis and prevention of errors to occupational therapy practice

Maximal Number of Participants: 40

Abstract:

Even the most accomplished occupational therapists make errors in practice. These errors result in minor to major consequences. The impact of errors on patients, therapists and others suggest the need for specific error prevention strategies to encourage safe practice. Thus, addressing patient safety is an important societal trend with quality and management of therapy services. Since 2001, with funding support from the Health Future Foundation and National Patient Safety Foundation this research team conducted a series of research projects focused on understanding practice errors and improving patient safety. One research outcome was a DVD with accompanying educational materials to disseminate to educators and clinicians. This DVD consisting of several case vignettes of common errors in therapy practice includes discussion of causative factors and strategies for prevention.
Teaching Methods: Linking research, education, practice, and evidence in a 1.5 hour workshop format with an interactive approach we will: (1) provide a brief overview of major findings from our research, (2) introduce key concepts and principles of human error and common patient safety terminology as they relate to occupational therapy practice, and (3) preview two vignettes based on common actual adverse events in occupational therapy practice found in our research data. After reviewing the vignettes the workshop attendees will be encouraged to add their perspective on causation and preventive strategies to the analysis of the cases. Participants will also be asked to share how these vignettes relate to their practice. The presenters will then discuss ways to report, disclose, and apologize when errors occur.