

【 資料 2 】		NPSEF の一例			
1. 効果的コミュニケーション		1. 1 患者および介護者を、パートナーとしてヘルスケアへ参画させている			
	Level 1 <i>For Category 1, 2 &amp; 3 health care workers</i>	Level 2 <i>For Category 2 &amp; 3 health care workers</i>	Level 3 <i>For Category 3 health care workers</i>	Level 4 <i>For Category 4 health care leaders</i>	
学習目標	患者とその付き添い人に必要な情報を必要な時に与えている	上手にコミュニケーションをとり、治療上の効果的な関係性においての良いコミュニケーションの役割を知っている	スタッフが患者と介護者にケアや治療に関わる機会を拡大している	医療サービスを計画し提供する際に患者や介護者をスタッフが参画させる戦略を開発している	
知識	(内容省略)	(内容省略)	(内容省略)	(内容省略)	

## V. 結果

### 1. 「医療安全管理者 Competency 自己評価表」

(巻末資料参照)

完成した「医療安全管理者 Competency 自己評価表」は、NPSEF に準じ、7つのカテゴリで構成され、カテゴリの下位に合計22の学習目標 (Learning objectives) が示された。さらに、その学習目標の達成を支援する要素として、「知識 (Knowledge)」「技能 (Skills)」「行動・態度 (Behaviors & attitudes)」に分類された306の項目が抽出された。

### 2. 「医療安全管理者 Competency 自己評価表」に抽出された NPSEF 項目の Level の傾向

NPSEF から「医療安全管理者 Competency 自己評価表」へ抽出した内容は、22の「学習目標 (Learning objectives)」では、Level 4 から 21 項目、Level 3 から 1 項目（「6. 継続学習 - 1. 学習者である」）の抽出であった。

また、「知識」「技能」「態度」の306項目を Level 別に見ると Level 4 全 227 項目中 180 項目、Level 3 全 265 項目中 136 項目と多く、Level 2 からは、3 項目のみ、Level 1 からは全く抽出されなかった。

NPSEF 項目総数と各 Level の抽出総数が異なっているのは、複数の Level の項目を併せて抽出したものがあつたためである。

### 3. NPSEF から「医療安全管理者 Competency 自己評価表」への項目抽出の検討に要した時間

NPSEF の翻訳の適切性および、抽出項目の精選は、原案をもとに、指導教官と共に各項目毎、討議しながら検討し、延べ約 32 時間を要した。

### 4. カリキュラムとの照合結果

前記に示した、3 団体のカリキュラムは、特に、医師会、看護協会のカリキュラムに基づく詳細内容が把握できなかったため、概要での照合となったが、ほぼ 3 施設のすべてのカリキュラムが NPSEF の示す Competency に含まれていた。

内容的にはそれが含まれると読みとれる項目もあるが、「FMEA などの未然防止手法の活用 (2-2 技能)」、「職務満足度調査の実施 (4-5 技能)」に関しては、新たな項目として加えた方が良いと思われたため追記した。

また、検討したカリキュラムの中には、「輸血」「転倒転落」が、特に重要な課題として取り上げられ教育されていたが、NPSEF では、これらに関して特別に分けられた記載は

されていなかった。

## 5. 「医療安全管理者 Competency 自己評価表」フォーマット

「医療安全管理者 Competency 自己評価表」のフォーマットは、自己評価の基準を以下の3段階で示すようにした。

- ① ×： 自己評価 50%以下
- ② △： 自己評価 50～80%
- ③ ○： 自己評価 80%以上

従来、医療安全管理者が配置される以前も、医療現場では、誰かが何らかの形で安全管理の一部を担ってきていた内容も多く、NPSEF に含まれている項目の中には、必ずしも日本の医療安全管理者が担っていない項目もあると考えられた。また、IT活用など、施設によっては、資源がないためできない環境も予測され、評価の中で記載できるような考慮が必要と考えた。

そこで、フォーマットの中に、「×の場合」の詳細が記載できるよう、以下の項目を加えた。

- ① 資源などが無い
- ② 他部門に委譲（委譲の場合→委譲している部門）

さらに、この評価表の有効活用を促進するために、「実行優先度」という項目を設け、医療安全管理者自身が評価後、どのような能力を優先的に育成していくことを考えるのかを明記できるようにした。優先度の記載は、特に基準を設けなかったが、全体の項目数が多いことから、次回評価するまでの期間を考慮し、5～7箇所程度にマーキングするのが現実的かと考えている。

## VI. 考察

今回、NPSEF をもとに、「医療安全管理者 Competency 自己評価表」の作成を試みた。一応の構造化はできたものの、その内容は膨大で、検討が不十分な点も多い。

今回は、上記結果を踏まえ、以下の点に関して、考察した。

### 1. NPSEF の示す Competency の特徴と、本研究における医療安全管理者 Competency の概念

Competency は、前述したように、一般に

6つの捉え方があるとされているが、NPSEF の示す内容は、まず、「学習目標 (Learning objectives)」を示し、その下位に「知識 (Knowledge)」「技能 (Skills)」「行動・態度 (Behaviors & attitudes)」などの項目を示している構造となっている。このような構造から、NPSEF が指す Competency の概念は、前記、①ある課業を遂行する能力 (Task Competency) と、④あることの知識・技能・態度などの能力 (KSA Competency) を併せたものに相当すると解釈される。

多くの Competency に関する文献では、⑤高業績者の（平均者との）差別性 (Superior-performer Competency) という定義を用いて活用しているものも多い。

しかし、本研究では、医療安全管理者の自己能力育成を目的とした Competency 評価表の作成を目指すものであったこと、我が国における医療安全管理者の活動の歴史が浅く一般的に必要な能力も明確に共有されていないことなどの理由から、特異的行動のみを示すのではなく、包括的な捉え方をした方が望ましいと思われ、NPSEF の捉える Competency の概念が、現状における我が国の医療安全管理者 Competency を検討する上で適したものであったと考える。

### 2. 評価項目数、フォーマットの検討の必要性

前述した方法に則り、医療安全管理者の Competency を、NPSEF をもとに抽出したが、その項目数は、306項目と膨大な数になった。

NPSEF の示す Competency は、非常に詳細に開発され、それぞれの行動の記述がなされていた。しかし、医療安全管理者という役割に該当する Competency は、明確に示されていなかった。そのため、今回は、該当する Category を、Category3 と 4 に焦点をあて検討し抽出したが、その双方の Category から選択される項目が多く、全体の項目数が多くなってしまった。

これらの項目は、今回の検討では、必要と考えられ抽出された項目ではあるが、自己評価するには実用が困難とも考えられる。

本研究では、時間的制約などから更なる厳選が出来なかったが、今後、実際に活躍している医療安全管理者からの評価を受け、その

意見と併せながら、項目を精選して整理していく必要があると考えている。

また、医療安全管理者は、その役割の性質上、臨床実践能力と管理能力を兼ね備えた上で、医療安全管理という専門的役割を担うという特徴をもっている。このように考えると、医療安全管理者の Competency は、そのベースに Category 3 があることを前提として、特異的に付加する項目を医療安全管理者独自の Level として追加する構造で考えることも出来るかも知れない。

あるいは、まず、22 の '学習目標' に対し評価し、その評価が低いものについて、その '知識' '技能' '態度' の項目を評価するといった、二重評価方式なら、評価者の負担を軽減できるとも考えられる。

二重評価方式をとらないとしても、'知識' '技能' '態度' の項目の総合的な位置づけとなる '学習目標' に対して、総合評価的自己評価記載欄を設けることは検討しても良いだろう。

自己評価の仕方としては、重要度と保有度のギャップを 'マッチングの状況' として 5 段階間隔尺度で表すよう示している文献もあり<sup>5)</sup>、評価方法の検討に関する課題は多い。

今後、これらのことを含め、医療安全管理実践者からの意見を求めながら、有効性を高められるよう修正する必要があると考えている。

### 3. 検討が必要な Competency

カリキュラムとの照合の結果、ほとんどの内容は NPSEF に含まれていたが、我が国でインシデント・アクシデント報告が多いとされている '転倒・転落'、有害事象に至った場合の患者影響度が大きい '輸血' に関しては、特記にも含まれていなかった。

'転倒・転落' に関しては、他の安全管理上の問題と分けて考えたほうが良い要素も多いためかもしれないが、予防対策など特有の内容も多く、今後、特記として扱う検討をする必要はあると考える。

また、'輸血' に関しては、7-2 の薬物に関する内容に入れることも考慮し、検討する必要がある。

今後、これらの内容や、医療安全管理実践者からの評価を受け、有効なエビデンスを踏まえて検討することで、我が国の医療安全管

理者の実践に則したものを追加することが望まれると考えている。

### 4. エビデンスを踏まえた医療安全管理者の Competency の検討

NPSEF の翻訳にあたり、大きな感慨を受けたことに、Competency 構築にあたってのエビデンスとなる文献の多さがあつた。

NPSEF の Competency の行動として示されている項目には、それぞれその科学的根拠となる文献が検索できるように符号されており、その数は、22 の学習目標毎にそれぞれ 20~40 以上にのぼっていた。

つまり、医療安全管理者の行動は、こうしたエビデンスに導かれたものであり、我々も、科学的根拠に根ざした行動が必要で、さらに、学習し続ける姿勢を養い研鑽していくことが重要であると強く感じた。

## Ⅶ. 本研究の限界

本研究は、オーストラリア NPSEF に基づき作成した「医療安全管理者 Competency 自己評価表」であり、内容検討は行っているが、我が国の医療安全管理者の実態との整合性を充分検討したものではないため、妥当性、信頼性、有効性の検討が必要である。また、翻訳上の問題で、表現上の工夫がさらに必要な項目も多いため、今後、さらに検討を重ね吟味していく必要があると考える。

## Ⅷ. 今後の課題

今回作成した「医療安全管理者 Competency 評価表」の信頼性、有用性を高めるため、自院での実践において活用し、広く他からの意見を求め再検討する必要があると考えている。

## Ⅸ. 結論

1. オーストラリア NPSEF をもとに、「医療安全管理者 Competency 自己評価表」を作成した。
2. 完成した「医療安全管理者 Competency 自己評価表」は、7つのカテゴリー、22の学習目標で構成され、306項目の知識・技能・態度が示された。
3. 我が国における医療安全教育カリキュラムとの照合により、さらに検討を要する事

- 項として、‘転倒・転落’‘輸血’が示唆された。
4. 作成した「医療安全管理者 Competency 自己評価表」は、全体的ボリュームも多く、また、妥当性、信頼性、有用性の検討には至っていないため、今後、医療安全管理実践者の客観的評価を得ながら、さらに内容を精選する必要がある。
4. 今後、精選を重ねた「医療安全管理 Competency 自己評価表」を有効活用することにより、医療安全管理者の自己能力育成の一助とすることが期待できる。

## X. 参考文献

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## **Educating the Workforce for Patient Safety**

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### **Background to patient safety education in Australia**

In 2005 a consortium, managed through the Centre for Innovation in Professional Health Education in the Faculty of Medicine at the University of Sydney developed a national framework for patient safety for the Australian Council for Safety and Quality in Health Care. (ACSQHC) The Framework was conceptualised, designed and written by A/Professor Merrilyn Walton.

Educating the workforce about patient safety requires a nationally coordinated and collaborative approach that involves all health professional and occupational groups. The national framework for education on patient safety is the blueprint for designing new educational programs about patient safety and for reviewing existing programs.

Until the development of the Framework there has been no uniform approach to patient safety education. Educational institutions, health services and professional training groups lacked common agreement, understanding and coordination of education on patient safety and quality improvement. This meant that patient safety and quality improvement activities were fragmented and lacked consistency across the health care sector.

The consortium that formed the development team included representation from universities, community, health system experts and educational experts. There was extensive consultation across the health care sector, including consumers. The Framework was developed using a consultative, evidence-based and inclusive approach, recognising the learning requirements of all health workers, irrespective of discipline or location.

### **The Australian National Patient Safety Education Framework**

- Identifies the key skills, knowledge, behaviours and attitudes related to patient safety for all health care workers
- Is a simple, flexible framework that can act as a benchmark for training, educating

and assessing health care workers in patient safety

- Will help make patient safety concepts easy for everyone to understand and apply
- Will help ensure all workers in the health system are equally competent and supported in adopting a patient-centred approach to their work

## **Principles Underpinning the Framework**

### *Safety is everybody's business*

The context for the National *Patient Safety Education Framework* is the individual health care worker in their workplace. Reducing adverse events and improving the quality of health care for the community can be achieved with well prepared health care workers who have the intention to and are ready to work safely. Health care workers who are educated and trained to work together can reduce risks to patients, themselves and their colleagues and when they manage incidents proactively maximise opportunities to learn from adverse events and near misses. Organisations also have responsibilities to provide the appropriate systems and networks to enable the workforce to learn and apply the skills and knowledge required for patient safety.

In the past most training and education in health care has been delivered using the learning objectives of a particular profession, occupation or discipline. This segregated approach is not appropriate in today's health care system where complexity, technology and specialisation are the norm. The approach used for the Framework moves away from the silo approach to training and education by identifying the learning necessary for each health care worker depending on their relationship or association with patients, clients or carers.

### *Patient centred*

The Framework is patient-centred and puts the recipients of health care (patients, clients and carers) at the centre of health care learning. The underpinning knowledge and understanding and the required demonstration of performance is designed to promote patient safety. Much of the learning (of knowledge and skills) will require health care workers to change the way they currently work.

Patients and the wider community have largely been passive observers to the significant changes in health care over the last three decades with the result that many patients do not fully participate in decisions about their health care. Nor have they been involved in discussions about the best way to deliver health services. The current clinician - centred and disease - focussed model emphasises professional and organisational domains without consideration of the patients who are at the receiving end of health care. Patients need to be at the centre of care; not at the receiving end of care.

There is strong evidence that patients can effectively self - managed their diseases with appropriate support. Decreased attention to the acute setting and increased attention to treating patients in multiple sites requires health care workers to put patient interests first - to seek and provide full information, to be respectful of their cultural and religious differences, to seek permission to treat and work with them, to be honest when things go

wrong or the care is sub optimal and to focus health services on prevention and minimisation of risk or harm.

### *The consumer perspective*

Consumer perspectives on health care needs reflect the changing need of care over the life cycle associated with staying healthy, getting better, living with illness or disability and coping with the end of life. The changing health care environment<sup>1</sup> including a shift from acute to chronic care, the need to handle a continually expanding evidence base and technological innovations, complex delivery arrangements, more care in teams and changing provider-patient relationships have created new demands on the health care workforce. This Framework recognises this changing environment and caters for a wide variety of patients in multiple situations and locations being treated by multiple health care workers.

### *Quality health care.*

The Framework recognises that if there is good quality health care than patient safety is enhanced. Therefore the dimensions of quality health care: safety, effectiveness, appropriateness, efficiency, access and effectiveness<sup>2</sup> have been included as themes in all the Learning Topics and are embedded in the Framework

### *Simple, flexible and accessible*

The Framework is simple, flexible and accessible to the stakeholders. This approach was necessary because of the complexity of the workplace and the breadth of knowledge, skills and behaviours associated with the learning topics. Stakeholders' needs in relation to developing curricula, workplace programs, workplace reforms and health care workers who use it to profile themselves were prime considerations in the structure of the Framework.

All users of the Framework need to easily navigate the topics and levels. This Framework allows the organisation or learner to identify the level of knowledge and skills they require to do their work or those they require if they wish to assume more responsibility for patient care or service delivery. While Foundation Level applies to all health care workers there will be a few instances in which a particular set of knowledge or skills may not apply to every health care worker. For example a manager of food services who because of their managerial responsibilities would be a Level 3 learner may not require the Level 3 competences around clinical practice.

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<sup>1</sup> Institute of Medicine Crossing the Quality Chasm: A new health system for the 21<sup>st</sup> Century. National Academy Press Washington DC 2001

<sup>2</sup> A Framework for managing the quality of health services in New South Wales NSW Health 1999.

## *Generic*

The Framework is designed for all health care workers. Training and education frameworks in the past have usually targeted a particular class or discipline of workers. This Framework assumes that safety is everybody's business, and not just the responsibility of doctors or nurses or a particular occupational group for a narrowly defined activity. A patient centred Framework starts with the patient and then asks 'what does this health care worker need to know today to keep this patient safe?' Therefore this Framework identifies the knowledge skills and behaviours that are required by health care workers in the workplace. In summary, a competent health care worker will know how to communicate effectively with patients, colleagues and managers, are well prepared, have the intention and are ready to work safely, reduce risks to patients, themselves, and their colleagues, works safely even after all foreseeable risks have been reduced, manage incidents appropriately and learn from mistakes.

## *Clear learning domains*

The Framework clearly sets out the required learning and demonstrated performance for a succinct and finite number of Learning Topics.

## *Progressive level of knowledge, skills and attitudes for all health care workers*

While safety is everybody's concern not everybody has the same responsibilities. This Framework recognises the different levels of knowledge, skills and attitudes required depending on where one works and their level of clinical or managerial responsibility for patients and clients.

The Framework commences with a Foundation Level of knowledge, skills and attitudes that are relevant and apply to everyone working in health care irrespective of their position, rank or location. The next two levels; Two and Three are designed for those with more hand on clinical and managerial responsibilities. An additional level has been developed for organisations. (Level Four) The learning outcomes are determined by the position of the health care worker and the place where they work. However, there will be nothing to prevent any health worker achieving learning outcomes from Levels more advanced than the one relevant to their position.

## *Recognition of prior learning*

The Framework is designed so that health care workers can move between levels but ensures that each health care worker knows the knowledge skills and behaviours required for the current position they hold.

## *Use of language*

The Framework uses plain English. The Companion Patient Safety Concepts and



Glossary<sup>3</sup> describes words and concepts that may not be familiar to many health care workers. The use of standard words across all levels is designed to help create a safer environment and assist to create a culture where safety language is not only common but understood by all irrespective of the position they hold in an organisation.

### *Evidence based or identifiable best practice*

The Framework has been built using the best available evidence from the literature about what people do that works to keep patients safe and from the experiences of health care workers at the coalface.<sup>4</sup>

### *Template for workplace and institutional learning*

This Framework is not a curriculum for patient safety rather it is a template from which individuals, organisations and institutions can develop curricula, educational programs or training packages confident that their programs will correctly identify the knowledge, skills and attitudes required by health care workers in the area of patient safety.

### *Educationally focussed*

The Framework is built upon broadly accepted principles of life long learning. It assumes that health workers will bring to its implementation a mature learner's view of life and learning.

## **The educational role of the framework**

As an educational tool the framework aims to provide a national guide to the required knowledge and performance elements needed by health care workers to take responsibility for patient safety. It may be used in conjunction with developing new or auditing existing educational curricula.

More specifically it includes:

- What all health care workers need to know and understand before performing their patient safety responsibilities (their general understanding and applied knowledge)
- What all health care workers need to be able to do to perform their patient safety responsibilities (performance elements)
- How this learning is distributed across varying levels of responsibility for patient safety in the health care system (levels of responsibility)

### *Building a framework matrix that integrates learning both horizontally and vertically*

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<sup>3</sup> The Glossary is in the Framework

<sup>4</sup> The Framework is accompanied by an extensive Bibliography that sets out all the key references underpinning the Framework.

The framework describes required learning using a “curriculum” matrix approach.<sup>5</sup> This approach, typical of a wide range of frameworks or curricula, lends itself particularly to modularization and hence the building of new programs as well as integration with existing programs.

Horizontally the scope of the framework integrates the content of 22 learning topics across 7 key learning areas. The content of each learning topic has a consistent internal structure which supports modular application.

Vertical integration in the framework is more subtle, using 4 levels of patient safety responsibility for each learning topic (Level 1 Foundation, Level 2, Level 3, and Level 4 Organisational). The specific work roles of health care workers can be viewed against these generic levels of responsibility.

Integration based on content and generic responsibility levels means that the framework can be independent of but adaptable to individual workplace duty statements.

### *Analysis by learning domains*

The framework development matrix uses the classical learning domains of knowledge, skills, behaviours and attitudes to identify the required learning within each learning topic.<sup>6</sup> Using these domains has provided a ‘first principles’ approach to the analysis of learning requirements. It has kept the focus on patient safety as evidenced in the literature, giving flexibility to how the learning requirements might be allocated to specific health care worker positions.

This first principles analysis of required learning has been translated into a framework document that is a performance-based learning guide. This was done by distinguishing between knowledge as general understanding and applied knowledge, while skills, behaviours and attitudes were coalesced into performance elements.

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<sup>5</sup> Curriculum matrices have long been used to describe the areas of learning in a program and their relationship to each other. Usually conforming to a column and row format, a typical matrix lists learning objectives against their contributing discipline and may be subdivided into modules or units to show how curriculum content develops over the duration of the program.

<sup>6</sup> The classic domains of learning distribute learning tasks across the three areas of:

- cognitive (knowledge)
- psychomotor (motor skills)
- affective (attitudes).

Using these overarching categories allowed early behaviourist and cognitive theorists to classify what was required to be learnt in terms of ‘learning objectives’. Perhaps the most famous of these was Benjamin Bloom whose *Taxonomy of Educational Objectives* (1956) is still widely used to support the analysis and writing of learning objectives, particularly where competency based learning needs to be assessed.

Both the development matrix and performance based documents are presented in the framework documentation to preserve the relationship between the original analysis and the performance based version.

### *Specifying 'performance'*

The framework describes required learning in terms of performance elements.<sup>7</sup> This provides a useful starting point for practice or workplace based training that relies on performance or competency based assessment. The decision by a health industry organisation or training provider to choose a competency based approach to assessment or credentialing will be their own. The framework performance elements will provide both learners and educators with a clear starting point to describe how successful learning might be demonstrated.

It is important to note that the framework does not specify full assessment or competency criteria. The detailed requirements for these will depend on which style of competency based curriculum is adopted.

### *Assuming adult learning principles*

The framework draws on its educational approach from the broadly accepted principles of life-long learning and assumes that health workers will bring to its implementation a mature learner's view of life and learning.

While there will be performance elements in the framework's learning topics that will be new to many health care workers, the project's broad consultation process has shown that much of what needs to be formally learnt and assessed relates closely to existing work and life experiences.

### *Supporting the design of practice-based implementation*

The framework is designed to educate the workforce using learning activities that are practice-based. Practice-based learning is a general term for learning that takes place as far as possible in the context of the learner's current work or professional environment. Learning activities, including assessments, need to be as authentic as possible and based on the requirements of the work role.

### *An integrated approach*

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<sup>7</sup> Performance outcomes are closely related to the required knowledge and performance elements as well as workplace training. To assess whether someone is competent in a task they are usually required to perform that task against a set of criteria. These often include a detailed description of the conditions under which the 'performance' should be attempted and how it should be measured.

Most modern curricula include the notion of integrated learning. This means simply that one part of the curriculum is not taught in isolation from other related or relevant pieces of learning.<sup>8</sup>

The framework aims to integrate learning requirements across all levels of the health care system, with particular emphasis on the both the foundation and organisational (or managerial) level. The latter will enable managers to support and positively reinforce the integration of learning about patient safety throughout the whole organisation, particularly in with critical strategies like team learning.

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<sup>8</sup> Although integrated learning can be quite difficult to manage as it often requires discipline experts from a number of different fields to combine their teaching in a cooperative effort. It can also require some innovation to be introduced as part of workplace learning where existing work practices don't currently support a team approach.

## Development of the National Patient Safety Framework Overview of Framework development

### Stage One

All the literature, books, reports, curricula and web sites were reviewed to identify the major activities associated with patient safety and whether they had a positive effect on quality and safety. These activities were then grouped into Learning Areas. Each Learning Area was analysed for the major subject areas. These subject areas were named Learning Topics. Rationales were written for each Learning Area and Learning Topic.

### Stage Two

Each Learning Topic formed the root for more extensive searching including additional search terms such as education, programs, training, adverse events, errors, mistakes and organisation/institution/health facility/health service. All the activities (knowledge, skills and behaviours) for each topic area were listed until no more activities were forthcoming and the sources exhausted. This list was then culled for duplication, practicality and redundancy. The activities were then categorised into a knowledge, skill or attitude/behaviour. The final stage was to allocate the item (knowledge, skill or attitude/behaviour) to one or more levels.

### LEARNING AREAS

Communicating effectively	Identifying preventing & managing adverse events & near misses	Using evidence & information	Working safely		Continuing learning	Specific issues
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### LEARNING TOPICS

Involving patient & families as partners in health care	Recognising preventing and managing adverse events and near misses	Employing best available evidenced based practice	Being a team player and showing leadership		Workplace learning	Preventing wrong site wrong procedure and wrong person treatment
Communicating risk	Managing risk	Using information technology to enhance safety	Understanding how human factors contribute to errors		Workplace teaching	Medicating safely

Communicating honestly with patients after adverse events	Understanding health care errors		Understanding complex organisations
Obtaining informed consent	Managing complaints		Providing continuity of care
Being culturally respectful and knowledgeable			Managing fatigue and stress in the workplace

<b>LEARNING DOMAINS</b>
Knowledge
Skill
Attitude/behaviour

### Stage Three

The activities were then categorised as knowledge, skills or attitudes/behaviours. The items (knowledge, skills or attitudes/behaviours) were then allocated to one or more levels as illustrated below.

## 1. Communicating effectively

### 1.1 Involving patients and carers as partners in health care

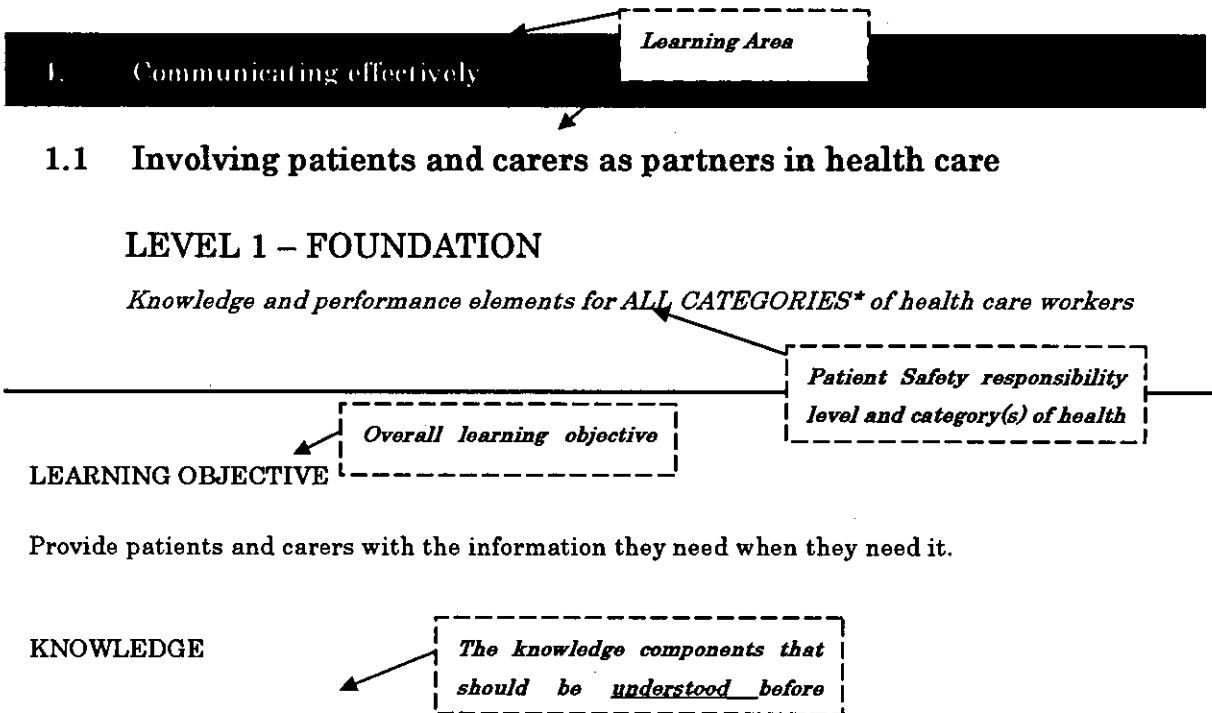
	Level 1 <i>For Category 1, 2 &amp; 3 health care workers</i>	Level 2 <i>For Category 2 &amp; 3 health care workers</i>	Level 3 <i>For Category 3 health care workers</i>	Level 4 <i>For Category 4 health care leaders</i>
Learning objectives	Give patients and carers the information they need when they need it.	Use good communication and know its role in effective health care relationships.	Maximise opportunities for staff to involve patients and carers in their care and treatment.	Develop strategies for staff to include patients and carers in planning and delivering health services.
Knowledge				
Skills				

Behaviours & attitudes				
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**Stage Four**

The completed context matrix which is on the next page was translated into a performance based format which takes full advantage of the modular nature of the framework.

Each Learning Topic is presented in the following format for consistency and ease of curriculum development.



*A general understanding of:*

- 1.1.1.1 the importance of respecting each patient's differences, religious and cultural beliefs, and individual needs.<sup>17</sup>

*The knowledge components that should be*

*An applied knowledge of:*

- 1.1.1.2 how to include patients and carers in discussions about safety<sup>17</sup>
- 1.1.1.3 how and when to use interpreter services.

#### PERFORMANCE ELEMENTS

*The key performance element that should*

- (i) Respond in the appropriate way to a patient in your workplace

*Demonstrates ability to:*

*The hierarchy of skills and behaviours needed to demonstrate*

- 1.1.1.4 actively encourage patients and carers to share their information
- 1.1.1.5 greet patients and carers appropriately<sup>18</sup>
- 1.1.1.6 listen carefully and be sensitive to patient and carer views<sup>19</sup>
- 1.1.1.7 ensure the patient or carer understands the information you have given them<sup>19 20</sup>
- 1.1.1.8 show empathy to patients and carers<sup>19</sup>
- 1.1.1.9 be honest with patients and carers<sup>22</sup>
- 1.1.1.10 show respect for patients and carers by being polite and avoiding negative comments<sup>20</sup>
- 1.1.1.11 comply with organisational protocols for electronic communication with patients and carers.

*Learning descriptor numbers. Eg 1.1.1.11*

#### \* CATEGORY DESCRIPTIONS

*CATEGORY 1 - Health care workers who provide support services*

*CATEGORY 2 - Health care workers who provide direct clinical care to patients and work under supervision*

## Review of the Literature

The literature on patient safety education is underdeveloped with few publications directly on the topic. Just two articles<sup>9</sup> appeared in January 2005 under the search term

<sup>9</sup> See Buysse DJ, Barzansky B, Dinges D, Hogan E, Hunt CE, Owens J, Rosekind M, Rosen R, Simon F, Veasey S, Wiest F. Sleep, fatigue, and medical training: setting an agenda for optimal learning and patient care. [Congresses] *Sleep*. 26(2):218-25, 2003 Mar 15 and Sokol P, Cummins DS. A needs assessment for patient safety education:



'patient safety education'. Therefore the Framework had to build its own infrastructure to identify the areas and topics considered central to patient safety.

The literature on patient safety is mainly Level III evidence comprising descriptive studies, reports, opinions of respected authorities, protocols and standards.

- I. Evidence obtained from at least one properly designed randomized controlled trial.
- II-1. Evidence obtained from well designed controlled trials without randomization.
- II-2. Evidence obtained from well-designed cohort or case-controlled analytic studies, preferably from more than one centre or research group.
- II-3. Evidence obtained from multiple time series with or without the intervention
- III. Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.<sup>10</sup>

The literature search incorporated a number of categories and subcategories including adverse events, quality improvement, mistakes, errors, education and training. These key search terms were identified from major reports, books and peer reviewed journal articles on patient safety.

The literature is biased towards hospital workforce and delivery systems. This was adjusted in the framework with generic descriptors being used to cover all possible locations and types of health service.

The literature did not identify knowledge, skills or attitudes for all those working in the health care system. When there was evidence of a safety role it mainly concerned the role of health professionals. Health workers who provided support services, those who worked in transport or the kitchen were under represented in most of the patient safety literature. This was compensated for by using the knowledge, skills or behaviours for a particular professional group and creating a separate set of knowledge, skills and behaviours that captured the essence of the activity in the context of the level of knowledge skills and behaviours required.

One of the main underlying principles pertaining to this Framework is that the competencies must directly relate to and be important to patients or clients. Putting the patient firmly in the centre of care requires that each piece of knowledge or application of a skill or attitude or behaviour demonstrated must enhance patient safety. The relevance of each element of knowledge, skill or behaviour was reviewed from the perspective of patients or clients.

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focusing on the nursing perspective. [Journal Article] *Nursing Economics*. 20(5):245-8, 2002 Sep-Oct.

<sup>10</sup> Eisenberg John M. What does evidence mean? Can the law and medicine be reconciled? *Journal of Health Politics, Policy and Law* 2001;26(2):369-81.)

## **Building the Framework**

The Framework Learning Areas were identified from the literature, major reports and books on patient safety. Each Learning Area selected was then analysed into subject areas. These subject areas became the Learning Topics.

Each Learning Topic combined with a range of search terms was used to generate a list of articles, books and reports about each topic. These were reviewed and used to compile a list of the knowledge, skills and behaviours required under each topic. This list was culled and collated into clusters of the main patient safety activities for each topic.

Each activity (a piece of knowledge, a particular skill or an attitude or behaviour) was then allocated to one of four levels. The first level or foundation identifies the knowledge, skills and behaviours associated with patient safety that everyone needs to have. Level Two is designed for health workers who work under supervision and/or are responsible for clinical care. Level Three health workers have managerial and supervisory responsibilities or are senior clinicians with advanced clinical responsibilities. Level Four competencies identify the knowledge, skills and attitudes required for organisations. Level Four does not form part of the progressive learning that underpins the first three levels. Although all people who work at an organisational level would be expected to have at least the Foundation Level of knowledge skills and behaviours.

The Learning Areas and Topics were discussed and endorsed by the Reference group and Steering Committee. Extensive consultation with the wider health system and community completed the review and endorsement process for the learning areas, topics and competencies.

### **The Rationales for each learning areas and topics**

Each Learning Area and Topic is introduced with a rationale outlining the importance of the subject. The rationales summarise the evidence supporting the learning area or topic and introduces concepts and terms used in this part of the Framework.

#### *Communicating effectively*

While communication is a theme running through all the Learning Areas and Topics it was considered essential to identify the knowledge skills and behaviours specifically for relating to patient clients and their carers. The topics in this Learning Area all focus on communication with patients or their carers in particular circumstances such as partners in health care delivery, the consent process, information about risk, honesty after adverse events and awareness and respect for diversity.

#### *Identifying preventing and managing adverse events and near misses*

Learning how to recognise adverse events and near misses, how to understand the underlying factors causing them and how to make improvements requires a skilled and

knowledgeable workforce with the intention to work safely. We also know that most adverse events and near misses are caused by poorly designed systems rather than an intended violation by an individual. If we remain focused on individuals we will not appreciate the complexity of health care delivery and as a result patients will continue to be harmed at an unacceptably high rate. This Learning Area and topics identifies the knowledge, skills and behaviours needed to reduce patient suffering from adverse events.

### *Using evidence and information*

Health care is supported by a large and ever increasing body of evidence. The speed and volume of new information today means that is impossible for health care workers to keep up to date with the latest knowledge. There are more than 40,000 biomedical journals currently published and the number doubles every 20 years.<sup>11</sup> To keep up to date a general practitioner would have to read 19 articles a day 365 days a year.<sup>12</sup> Knowing how to obtain the latest reliable and evidenced based information is crucial for patient safety. The Framework recognises the different requirements for health care workers in relation to contemporaneous knowledge.

Many of the Framework competencies identified for health care workers in this Learning Area will be new and many health care workers will not have access to computers or other technology. But future health care will increasingly rely upon informatics and the workforce must be educated to use it. There is good evidence that shows the use of technology such as reminder and support systems, order entry systems, telemedicine, online prescribing, teleradiology and email improve the quality of patient care and can reduce adverse events.

### *Working safely*

Four topics were selected for this Learning Area: team work, human factors, complex organisations and continuity of care. They were selected because the literature shows that just applying knowledge and skills about diseases and medical conditions alone does not prevent adverse events or errors in health care delivery. Managing stress and fatigue as well as applying knowledge about human factors and organisational complexity and the steps and processes involved in patients' journeys through the health system are equally important for preventing harm to patients.

Working safely and providing continuity of care for patients depends on every health care worker knowing their role in the organisation and how to work with other members of the health care team.

### *Being ethical*

Community trust in health care will be maintained by designing a health system that

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<sup>11</sup> Wyatt J Use and sources of medical knowledge Lancet 1991;338:1368-7

<sup>12</sup> Davidoff F Haynes B Sackett D Smith R Evidence based medicine; a new journal to help doctors to identify the information they need BMJ 1996;310:1085-6

delivers safe and quality health care and one where a strong professional ethic thrives. Ethical practice in the workplace was selected as a Learning Area because professionalism and ethics in the workplace need to become part of the safety agenda. The perceived contest between whether individuals or bad systems cause patient injuries has confused many health professionals and managers. It is not a case of accepting one over the other. The focus on the system as the problem does not mean that individuals do not have to maintain competence and practice ethically or be called to account when they act unprofessionally. Health care workers also need to know the methods for managing and responding to intentional violations by individuals in the workplace.

### *Continuing learning*

Knowing how to access and evaluate information is one part of managing the volume of health care information and the other part is ensuring those in the workplace acquire the new knowledge and skills so they can perform their duties. All health care workers have a responsibility to be involved in learning and teaching in the workplace. Innovative teaching methods for educating and training learners is an essential element of creating learning cultures. Sharing skills, knowledge and experiences with other workers and members of their health care team is just one method. There are many more.

### *Specific issues*

Two areas stand out for further attention in relation to preparedness of health care workers. Adverse events involving wrong patient, site or procedure along with medication errors constitute a significant proportion of the 'never should happen' events causing great harm to patients. Ensuring the right patient receives the right treatment requires that staff in all categories follow best practice guidelines and protocols. Administering medications to patients is particularly prone to errors because of the multiple steps involved.

The framework is designed to be a template for curricula development, so those organisations with a specific interest in these two problem areas can design curricula and workplace programs using the specific set of knowledge, skills and attitudes identified for health care workers. In the future other problem areas may need to be integrated into the framework and further competencies developed. Conversely, as the workforce becomes more competent in these areas the need for separate treatment of some topics will diminish and integrate into the framework.

## **The structure for the Framework**

The literature on existing patient safety education and training frameworks was reviewed. While there are many education and training frameworks available particularly in the vocational and educational sector, not many directly relate to educating health workers about patient safety. The most relevant to this project was the