Submission ID: 41.

Primary Subject Area :Patient safety in general practice.
Format: Oral presentation.

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Title: ***Developing healthcare professionals' reflective reasoning, an essential feature for patient safety***.

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Abstract

Background and aim

The Association Mieux Prescrire (AMP), is an independent organisation providing continuous education for healthcare professionals. AMP is entirely funded by its subscribers. AMP's activities in professional development are accredited. In 2007, AMP set up the program Éviter l'Évitable (Preventing the Preventable), a practice based improvement program on error reporting and learning system for healthcare providers, especially primary care. Prescrire subscribers are stimulated to develop a patient safety culture through evidence based information, appropriate tools and logistical support. Experience with the program shows that healthcare professional's "reflective reasoning", is a key component to develop patient safety.

The objective is reflective reasoning as a professional skill. Among all skills to improve patient safety, healthcare professionals' reflective reasoning is the ability to reflect on one's own actions, specifically on errors and preventable adverse events. At an individual level, the impact of errors on healthcare providers and their fears of bad outcomes and disclosure make it difficult to report adverse events.

However, being aware of an error, and being able to discuss it, opens the way to a process to improve one's own practice, and the interaction with other healthcare organisations. Subscribers find support in the articles published in the revue Prescrire about error prevention, and also in taking part in the error reporting and learning system. Confidential interviews with an analyst from the program allow establishing a precise chronology of the events. It is the first step towards reflective reasoning. Extending an individual reflective approach, to a multi professional systemic analysis of adverse events can be done by all healthcare providers. Collective analysis of adverse events helps to improve communication and develops a safety culture. Subscribers can also attend face-to-face workshops, during the meetings (Rencontres Prescrire).

Methods

Tools developed by Prescrire include 3 approaches: 1) Educational (training of subscribers, error analysts, group moderators) 2) intervention-action (for subscribers: comparing case reports with EB research findings of good practice; for the Prescrire team: assessing the performance of the reporting system); -3) research on clinical practice (eg analysis of care processes leading to practice recommendations and workshops).

These approaches are interrelated, since the program is designed as a self-learning and evolving process. Various tools are available for subscribers: training materials for CPD: the journal Revue Prescrire, an electronic library with systematic indexing, a validated reading test of the journal, especially for students, the error reporting and learning program that targets healthcare providers subscribers of the journal who want to promote these ideas, training support to improve practices through a collectively predefined program by themes (mainly online); face-to-face WS specifically designed to work on error (Dodécagroupe°, group training of GPs in Belgium, University of Caen); Online WS proposed on specific theme (eg the risk of error linked with the international non proprietary name), or on the basis of reported cases.

Conclusion

Working on errors in healthcare helps to overcome obstacles to achieve high quality of care for all, and depends on caregivers' capacity to reflect and act to overcome their reluctance. The Preventing the Preventable program is at the same time an educational experience, an action to improve healthcare, a research applied to practice. Reflective reasoning is the main component of a patient safety culture. It becomes really effective only when all caregivers involved in the occurrence of an adverse event participate in the process. It is possible to move with small steps from an individual approach to a collective approach to promote patient safety.