



Postgraduate Institute for Medicine

EVALUATION FORM

Patient Safety: The Human Factor – Effective Teamwork and Communications

Project ID: 2645ES22

Postgraduate Institute for Medicine (PIM) respects and appreciates your opinions. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form. ***You must complete this evaluation form to receive acknowledgement of participation for this activity.***

Prior to submitting the evaluation form to the Postgraduate Institute for Medicine, submit a \$20 CE processing fee for each submitted form to Visible Productions:

- Log on to www.errormedicine.com/orderCME.html
- Follow the instructions for making a credit card payment through PayPal
- Print out a copy of the payment confirmation

Upon completion, please mail or fax the evaluation form and receipt of payment confirmation from PayPal to:
Postgraduate Institute for Medicine
367 Inverness Parkway, Suite 225
Englewood, CO 80112
Fax: 303-790-4876

Please answer the following questions by circling the appropriate rating:

5 = Outstanding 4 = Good 3 = Satisfactory 2 = Fair 1 = Poor

Extent to Which Program Activities Met the Identified Purpose and Objectives

Purpose:

- Given the essential nature of patient safety, it is necessary for all healthcare practitioners to be informed about all available methods to improve the safety and quality of care in order to provide optimal outcomes for their patients. 5 4 3 2 1

Upon completion of this activity, participants should be better able to:

- Describe the critical importance of effective team work and communication in delivering safe care. 5 4 3 2 1
- Discuss the concept of high reliability in designing systems to insure safe care. 5 4 3 2 1
- Summarize the 2005 JCAHO patient safety goals. 5 4 3 2 1
- Explain the importance of assertion and critical language when clinicians have a concern about care. 5 4 3 2 1
- Describe a practical situational briefing model to enhance effective communication. 5 4 3 2 1

Overall Effectiveness of the Activity

Was timely and will influence how I practice	5	4	3	2	1
Will assist me in improving patient care	5	4	3	2	1
Fulfilled my educational needs	5	4	3	2	1
Avoided commercial bias or influence	5	4	3	2	1

Impact of the Activity

The information presented:
(check all that apply)

- Reinforced my current practice/treatment habits
- Will improve my practice/patient outcomes
- Provided new ideas or information I expect to use
- Enhanced my current knowledge base

Will the information presented cause you to make any changes in your practice? Yes No

If yes, please describe any change(s) you plan to make in your practice as a result of this activity:

How committed are you to making these changes? 5 (Very committed) 4 3 2 1 (Not at all committed)

Future Activities

Do you feel future activities on this subject matter are necessary and/or important to your practice? Yes No

Please list any other topics that would be of interest to you for future educational activities:

Follow-up

As part of our ongoing continuous quality-improvement effort, we conduct post-activity follow-up surveys to assess the impact of our educational interventions on professional practice. Please indicate your willingness to participate in such a survey:

- Yes, I would be interested in participating in a follow-up survey
- No, I'm not interested in participating in a follow-up survey

Additional comments about this activity:

If you wish to receive acknowledgement of participation for this activity, please complete the posttest by selecting the best answer to each question and filling in the answers in the Posttest Answer Key, complete this evaluation verification of participation, print a receipt of payment confirmation through PayPal, and FAX to: 303-790-4876 or mail to:

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 367 Inverness Parkway, Suite 225
 Englewood, CO 80112
 Fax: 303-790-4876

Posttest Answer Key

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34						

Request for Credit

Name _____ Degree _____

Organization _____ Specialty _____

Address _____

City, State, Zip _____

Telephone _____ Fax _____ E-Mail _____

I certify my actual time spent to complete this educational activity to be:

For Physicians Only

- I participated in the entire activity and claim 2.75 credits.
- I participated in only part of the activity and claim _____ credits.

Signature _____ Date Completed _____