



Postgraduate Institute
for Medicine

POSTTEST

Patient Safety: The Human Factor – Effective Teamwork and Communications Project ID: 2645ES22

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MODULE 1

1. In the clinical example of switching two “look-alike” drugs, the mistake could be avoided by:
 - a. Having clinicians be more diligent
 - b. More continuing education
 - c. A system solution that physically separates similar appearing medications
 - d. Relying on clinicians to report mistakes and close calls
2. The overwhelming majority of medical errors resulting in patient harm result from:
 - a. Clinicians not paying attention
 - b. Good people set up to fail in unsafe systems
 - c. People not trying hard enough
 - d. Patients are sick
3. The most common cause of unanticipated adverse events in patient care is:
 - a. communication failure
 - b. people are sick
 - c. medical equipment failures
 - d. illegible handwriting

4. What percentage of the American public believes they have had personal experience with a medical error?
- 5%
 - 20%
 - 40%
 - 70%
5. What is least important to patients in the aftermath of an episode of medical harm?
- being told the truth
 - receiving an apology
 - being told what will be changed to prevent someone else being hurt in the same way
 - hearing that the care providers will be disciplined

MODULE 2

6. The current culture of medicine:
- makes it hard to talk about mistakes
 - is very accepting of errors
 - does not equate clinical performance with competence
 - is not based on the physician as an individual expert
7. With regard to communication styles, nurses are trained to:
- require that doctors justify their diagnostic conclusions
 - describe things in broad narrative terms
 - use diagnoses in describing changes in patient status
 - just supply the “headlines”
8. 24 hours without sleep is equivalent to a blood alcohol of ____% in processing complex information?
- 0.05
 - 0.02
 - 0.08
 - 0.10
9. The human brain can hold how many pieces of information in short term memory?
- an infinite number
 - 2-3
 - 5-7
 - 12-15
10. Acute stress:
- does not effect the performance of highly trained individuals
 - can lead to “tunnel vision”
 - is uncommon in clinical care
 - can be overcome by trying harder

11. Safety attitude surveys often reveal that doctors and nurses working in intensive units:
 - a. perceive different levels of teamwork and collaboration
 - b. don't think teamwork is important
 - c. all like each other
 - d. are always on the "same page"

12. In Judy Baggs' 1994 study, when the nurses described the decision to transfer a patient out of the ICU as a collaborative, shared decision, what was the difference in patient outcome?
 - a. 5% of patients were returned to the ICU or died during that hospitalization
 - b. 16% of patients were returned to the ICU or died during that hospitalization
 - c. there was no difference

13. The most important factor in providing safe care is:
 - a. effective teamwork and communication
 - b. better technology
 - c. people trying harder
 - d. computerized medical records

MODULE 3

14. One of the basic concepts of high reliability organizations is:
 - a. complex systems prevent the application of rules
 - b. simple rules for complex systems
 - c. highly skilled, motivated people don't make mistakes
 - d. technology will prevent all errors

15. In the concept of high reliability, preoccupation with failure means:
 - a. team members voicing concerns are being overly cautious
 - b. thinking about potential problems causes people to become "tunnel-visioned"
 - c. chicken little is alive and well
 - d. any concern voiced by a team member is taken seriously

16. What similarities do medicine and aviation NOT have in common?
 - a. highly trained professionals interact with technology
 - b. operational pressures are common
 - c. risk and potential harm are present
 - d. aviation is far more complex than medical care

17. In commercial aviation accidents, communication failures among the crew are:
 - a. rare
 - b. a major factor in 70% of accidents
 - c. less important than mechanical failures
 - d. eliminated by extra technical training

MODULE 4

18. In surveys of healthcare providers, what percentage indicates that briefing is a good idea?
- 20%
 - 35%
 - 50%
 - 90%
19. The purpose of holding a short briefing prior to a procedure is to:
- set the tone for positive team work
 - create a shared mental model of the plan and tasks at hand
 - give permission for communication of concerns and suggestions
 - all of the above
20. When is it **not** a good time to brief?
- when there have been changes in the plan of care
 - after the care has been delivered
 - if new team members join in
 - when the team first comes together
21. The Safety Attitude Survey reveals that:
- Knowing other team members names is not important if everyone acts professionally.
 - Doctors frequently know names of all of the team members.
 - People rarely feel hesitant to speak up with their concerns.
 - Nurses most often know the names of other team members.
22. In a University of Texas OR study done in Switzerland, OR nurses said the most important factor in determining whether it was a good day or bad day was:
- if the surgical case started on time
 - the other people in the OR knew them by name
 - the sponge count was correct
 - X-ray was available if they needed it
23. In the SBAR model, which of the following is **not** a component?
- situation
 - assignment list
 - assessment
 - recommendations
24. With regard to SBAR, the situational briefing model, which is **not** correct?
- helps insure effective communication by creating a predictable structure
 - is only useful if experts use it
 - helps bridge the difference in communication style between doctors and nurses
 - is very efficient

MODULE 5

25. Appropriate assertion is critically important in assuring patient safety because:
- Often someone knows there is a problem, but may have trouble speaking up.
 - People are often rude and interrupt.
 - Creating an atmosphere where team members can express their concerns openly happens automatically.
 - Team leaders are always open to input.
26. Normalization of deviance refers to what?
- cutting corners being seen as business as usual
 - letting a bunch of strange people take care of patients
 - averaging clinical outcomes as a measure of clinical care quality
 - a formula for identifying outliers
27. The importance of a creating a flat hierarchy for effective teamwork is:
- everyone has equal authority
 - to create an environment that feels safe to speak up and voice concerns
 - be sure all decisions are made through consensus
 - to foster group think
28. Effective leaders are:
- all knowing
 - open to suggestions
 - leave no doubt who the boss is
 - quick to point out mistakes other team members make
29. In the “CUS” model of critical language, which is **not** part of the acronym?
- uncomfortable
 - scared
 - concerned
 - “I have a problem with you”
30. Use of critical language is very useful:
- because in some cultures speaking directly and suggesting someone is making a mistake is regarded as rude
 - when people are screwing up they need to be told
 - being critical of people helps them learn
 - you have to be blunt for people to understand

MODULE 6

31. Which of the following is **not** a part of the Joint Commission Patient Safety Standards?
- A process for medication reconciliation across the care continuum.
 - Read-backs on verbal orders
 - Nosocomial infections are not treated as sentinel events
 - For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back”.
32. With regard to hospital acquired infections, which is **not** correct?
- estimates are that some 10,000 patients per year die of hospital acquired infection that could be prevented by good hygiene among health care workers
 - the Center for Disease Control has created clear and extensive guidelines for hand hygiene
 - all serious events associated with hospital acquired infections should be treated as sentinel events
 - prophylactic antibiotics have greatly reduced this problem
33. JCAHO guidelines to enhance medication safety include all of the following except:
- Standardize and limit the number of drug concentrations available in the organization.
 - Make a list of look-alike/sound-alike drugs, and take steps to prevent errors from the interchange of these drugs
 - Label all medications in perioperative and other procedural settings.
 - Require all caregivers dispensing medications to do the “5 rights.”
34. JCAHO guidelines to ensure effective communication among care providers includes all of the following **except**:
- read-backs of verbal orders
 - improving physician handwriting
 - standardizing the use of acronyms and abbreviations
 - Structured communication for hand-offs