**Title**: MVCM.TK.216 The science of patient safety and the burden of unsafe care

**Amount of credits**: 2 (52 academic hours)

**Final assessment**: Non-differentiated (pass, fail, absent)

**Additional information**: The course corresponds to the module Fundamentals in patient safety and is prerequisite to “Methods of analysis and improvement of adverse events (I)”

**Objectives**
- To describe and raise awareness of why patient safety has emerged as an important issue in healthcare
- To identify the impact of adverse events at different levels of care (including the extent of specific adverse events such as nosocomial infection, events related to medication and others)
- To describe the methods used for epidemiological studies of adverse events
- To identify how to define the severity and preventability of adverse events
- To describe existing taxonomies on patient safety and their potential applications in research
- To describe basic definitions and foundational concepts, including human factors and organizational theory
- To list and discuss major types of errors and related latent conditions
- To explain how system design and the influence of human factors affect healthcare outcomes
- To identify research gaps in the area of the burden of unsafe care

**Learning outcomes**
The students who have completed the course will be able to:
- Prioritize patient safety issues, focusing on the main adverse events in their work field or clinical setting
- Use a standardized vocabulary and concepts as an essential requirement for effective patient safety research and improvement (including the need for distilling complex interventions into their essential components, facilitating comparisons and promoting clear communications with different stakeholders)
- Introduce a non-punitive approach to research activities and improvement efforts related to patient safety.
- Recognize research areas related to the burden of unsafe care in their local area or clinical setting.

### Brief description of the content
- Patient safety as a dimension of quality of care
- Epidemiology and nature of adverse events
- Methods for studying the impact of adverse events
- Identification of specific adverse events (e.g., surgical adverse events, nosocomial infections, medication, falls)
- Basic concepts of patient safety
- Errors and the human factors in the patient safety science
- Taxonomy of patient safety.

### Learning methods
- Face-to-face group learning sessions (workshops)
- Writing assignments
- Online forum participation
- Video lectures of international experts and the teaching team
- Experiential learning (including literature searches and critical analysis of scientific literature, designing and/or performing studies related with the science of patient safety and the burden of unsafe care)
- Case-based learning.