**Proforma**

**Section 2: Self-assessment of knowledge (Post-pre- and post-test)**

1. Please answer the following questions on a 5-point Likert scale (post-test).
2. In a hypothetical scenario where you had not attended this module, please indicate how your answers would have differed/remained same on a 5-point Likert scale (post-pre-test).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | Item # | **I feel confident in what I learned about….** |
| Working in teams with other health professionals (WT) | 1. | Managing inter-professional conflict |
| 2. | Encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues |
| Communicating Effectively (Com) | 3. | Enhancing patient safety through clear and communication with patients |
| 4. | Enhancing patient safety through effective communication with other healthcare providers |
| 5. | Effective verbal and nonverbal communication abilities to prevent adverse events |
| Managing Risks (MR) | 6. | Recognizing routine situations in which safety problems may arise |
| 7. | Identifying and implementing safety solutions |
| 8. | Anticipating and managing high risk situations |
| Understanding human and environmental factors (UHE) | 9. | The role of human factors, such as fatigue, which effect patient safety |
| Recognize and respond to reduce harm, (RRRH) | 10. | Recognizing an adverse event or close call |
| 11. | Reducing harm by addressing immediate risks for patients and others involved |
| Culture of safety (CS) | 12. | The importance of having a questioning attitude and speaking up when you see things that may be unsafe |
| 13. | The importance of a supportive environment that encourages patients and providers to speak up when they have safety concerns |
| 14. | The nature of systems (e.g., aspects of the organization, management or the work environment including policies, resources, communication and other processes) and system failures and their role in adverse events |
| Infection Control (IC) | 15. | I know what to do when entering the room of a patient on isolation precaution. |
| 16. | I know how to use Personal Protective Equipment such as gowns, gloves, masks and when it is appropriate |
| Error Disclosure (ED) | 17. | I know where and how to submit an error report in the hospital error reporting system |
| Medical Documentation (MD) | 18. | I know how use of abbreviations during medical record documentation can lead to inadvertent errors |

**Section 3:**

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| --- | --- | --- | --- | --- | --- |
| **Systems Thinking Scale (pre- and post-test)** | | | | | |
| **Making Improvement**  **Instructions:**    Please read each of the statements and place an “x” in the answer box that indicates frequency of agreement with the statement: | | | | | |
| **When I want to make an improvement. . .** | **Never** | **Seldom** | **Some of the time** | **Often** | **Most of the time** |
| 1. I seek everyone’s view of the situation. |  |  |  |  |  |
| 1. I look beyond a specific event to determine the cause of the problem. |  |  |  |  |  |
| 1. I think understanding how the chain of events occur is crucial. |  |  |  |  |  |
| 1. I include people in my work unit to find a solution. |  |  |  |  |  |
| 1. I think recurring patterns are more important than any one specific event. |  |  |  |  |  |
| 1. I think of the problem at hand as a series of connected issues. |  |  |  |  |  |
| 1. I consider the cause and effect that is occurring in a situation. |  |  |  |  |  |
| 1. I consider the relationships among coworkers in the work unit. |  |  |  |  |  |
| 1. I think that systems are constantly changing. |  |  |  |  |  |
| 1. I propose solutions that affect the work environment, not specific individuals. |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **When I want to make an improvement. . .** | **Never** | **Seldom** | **Some of the time** | **Often** | **Most of the time** |
| 1. I keep in mind that proposed changes can affect the whole system. |  |  |  |  |  |
| 1. I think more than one or two people are needed to have success. |  |  |  |  |  |
| 1. I keep the mission and purpose of the organization in mind. |  |  |  |  |  |
| 1. I think small changes can produce important results. |  |  |  |  |  |
| 1. I consider how multiple changes affect each other. |  |  |  |  |  |
| 1. I think about how different employees might be affected by the improvement. |  |  |  |  |  |
| 1. I try strategies that do not rely on people’s memory. |  |  |  |  |  |
| 1. I recognize system problems are influenced by past events. |  |  |  |  |  |
| 1. I consider the past history and culture of the work unit. |  |  |  |  |  |
| 1. I consider that the same action can have different effects over time, depending on the state of the system. |  |  |  |  |  |

**Section 5: Personal Reflections (post-test)**

This section for personal reflection is a platform for student to share their thoughts and ideas about the course. Students should take advantage of it to take note of personal thoughts, brainstorm learnings, and explore how the course has influenced them. The reflection will only receive a completion grade; therefore, students should express without hesitancy as this is an open-ended assignment.

**·**     Reflection should be at least 90 words in length

**·**     Write about anything that came to your mind during the course including but not limited to questions, thoughts, and ideas, etc.

**·**   **Some points to consider as you write:**

* What were your reactions to the examples you heard involving medical errors?
* How would you summarize what you have learned?
* What were your thoughts and feelings as the course progressed?
* Any personal or familial experiences that resonated because of the course?
* Do you have any new ideas that may help decrease medical errors in the future?
* How has the course affected or changed your thinking?
* What are you taking away from the course?