



The Patient Safety  
Education Program™  
CANADA

Module 15: Capacity Building:  
Transferring PSEP – Canada  
Knowledge to your Organization

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# Abstract

Slide 1



Module 15

Capacity Building:  
Transferring PSEP – Canada  
Knowledge to your Organization

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This module provides PSEP – Canada trainers with an understanding of how they can take what they have learned and transfer that knowledge to spread and embed practical application of patient safety strategies into their organizations. Patient safety improvements require local capacity to determine priorities and to develop or adapt to local solutions. The module will provide Trainers with the knowledge, skills and tools to enhance patient safety endeavors in their organizations.

# Keywords

Capacity building, sustainability, knowledge transfer, leadership support, skills transfer, knowledge translation, learning application, workplace learning success, patient safety sustainability, sustaining patient safety practices, behavior change, patient safety, quality improvement

# Teaching methods

Interactive lecture, storytelling, video observation, large group discussion

# Objectives

Slide 2

## Knowledge requirements

- Understand what is required to develop patient safety capacity in health care organizations following the PSEP – Canada program

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Slide 3

### Performance requirements

- Describe the best methods to apply PSEP – Canada learnings to home organizations, and
- Create within an organization a culture committed to ensuring patient safety

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The learning objectives of this module are to transfer PSEP – Canada knowledge to the spread and practical application of patient safety strategies in their organizations.

### Knowledge requirements

The knowledge elements include an understanding of:

- what is required to develop patient safety capacity in health care organizations following the PSEP – Canada program.

### Performance requirements

The performance elements include the ability to:

- describe the best methods to apply PSEP – Canada learnings to home organizations, and
- create within an organization a culture committed to ensuring patient safety.

## Introduction

Slide 4

### Introduction

- The challenges
- From theory to practice
- Change management
- The opportunities

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When PSEP – Canada trainers return to their home organizations they often find it challenging to transfer and share what they have learned through the PSEP – Canada program with their organizations. Colleagues and leaders, who are busy with their day-to-day work, may not be easily convinced of what is required to develop a culture

committed to patient safety. They may, therefore, not prioritize or support the work that is needed to bring patient safety education to their organizations. PSEP – Canada trainers may also feel isolated and unclear as to how to begin the transfer of their knowledge to the organization. Understanding the types of challenges that PSEP – Canada trainers may encounter and the opportunities to pursue to address those challenges is critical to successfully spreading patient safety knowledge throughout an organization.

This module focuses on the concept of capacity building within an organization, specifically focusing on change management principles and how PSEP – Canada trainers can return to their organization with strategies to help ensure successful spread and sustainability of patient safety knowledge.

## The challenges

Slide 5

### The challenges

- Too many projects happening
- Lack of leadership support
- Lack of time and energy
- Leadership support but no funds available
- Education saturation

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Taking advantage of opportunities entails fully understanding the reality of the work environment. What are the attitudes toward education, why? What support is provided to those that do attend education? What is the learning culture of the organization? Is it adequately supported, is there an appetite for learning? In many cases, trainees encounter:

- too many projects happening, staff are burned out with doing “extra” work;
- lack of leadership support, staff attend education sessions in their free-time, there aren’t any provisions to “back-fill” positions so that staff can attend education sessions during work hours;
- limited staff, overworked staff are too tired to consider attending education sessions;
- limited resources to support quality programming and alleviate the stress of learning defined as additional work; and
- too many education sessions are available to staff, some perhaps of poor quality so the attitude of staff toward education is negative.

# Case discussions

Slide 6

## Case discussions



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A number of trainers have had experience with the challenges associated with trying to transfer PSEP – Canada expertise to their organizations. The lessons learned from those experiences reveal the necessity to:

- seek executive support to prioritize patient safety education,
- maintain momentum so that PSEP – Canada learning is not lost while waiting for policies and procedures to be put into place, and
- prioritize and maximize time so that patient safety education does not become an added burden to an organization.

The following 3 scenarios provide specific examples of challenges faced by trainers returning to their organizations.

## Executive endorsement

After attending the PSEP – Canada program, Jordan returned to an organization in turmoil. A number of the departments were in the process of merging. As a result, her supervisor was transferred and it was not clear to whom she would be reporting to. Jordan had had a solid relationship with her supervisor and was confident that together they would be able to make a difference for patient safety. Given the changes, she was no longer as confident as she had been.

She was disappointed with the change and knew that she needed executive level support to be able to deliver the PSEP – Canada program successfully within her organization. Her challenge was to find the right support while the information was still fresh and while she was keen to spread all that she had learned throughout the organization. After a period of time, the Vice President (VP) of Quality Improvement and Risk Management was appointed. Jordan was to report directly to her. They were both trying to understand each other and the VP was new to the portfolio and desperately trying to understand her job. Jordan waited until the moment was right before approaching the new VP about the PSEP – Canada program. It took 6 months for that moment to arrive and Jordan was frustrated by the time that was lost.

Fortunately, Jordan was sent to the PSEP – Canada program along with 11 other staff from other hospitals in the area. They met together and decided to establish a common charter detailing, in writing, their goals and objectives for the PSEP – Canada training that they had received. This was done shortly after their return from the training. The team met at regular intervals while they were waiting for executive level support. They were determined to be able to begin work as soon as the support came through at each of their organizations. As a result they were ready to submit a completed charter to their executive champions whenever support was provided. The champion was then equipped with adequate information to relay to the Senior Executive team for their endorsement.

If she were to do it over again, Jordan would not wait for the perfect environment to begin patient safety education initiatives. She would not wait to be told what to do and how to do it by an executive representative. Patient safety programming should not stop because of internal changes—it cannot wait for perfect timing.

Instead, she would connect with executives early, despite any uncertainty in the hierarchy. She would begin by approaching the VPs of specific targeted services. She would let them know why they needed the program; she would give them facts and figures. She would include the current number of patient safety incidents and how the organizational results compare with the rest of the province and the country. She would also tell them about the cost implications for patient safety incidents and inform them of the Patient Safety Culture survey results. In a time of fiscal restraint, the executive level needs and wants to know the bottom line and the cost implications of not doing patient safety training.

She would also remind them that patient safety training is an Accreditation Canada Required Organizational Practice. Finally, she would link it all back to the Strategic Plan and the organization’s mission and vision. She would show how the PSEP – Canada program links as a priority to achieving the organization’s mission and vision.

If she were to do it all again, she would also have a detailed conversation with the executives sending her to the PSEP – Canada training BEFORE the training, to find out their expectations of the training. If that were not possible, she would meet with them immediately following the training to brainstorm ideas of how to spread the knowledge gained from the PSEP – Canada program. She would ask: What are their expectations? Who should be doing what? What are the goals to put the program into place internally?

What actually happened was that once the Executive Teams had endorsed the Charter, the 12 PSEP – Canada trainers gave presentations to the leadership level of their respective organizations (VP and Director level staff) on their plan, the value of the program and the plan for roll out. They also told the leaders the cost implications so that they could plan accordingly. The 12 trainers then developed a shared webinar for managers containing similar content as the presentation for the next level of leaders, but in addition, they asked those leaders to commit to send 3 staff per service area to a training session that would happen later in the year. The training program that was planned was a 4 day program.

Each of the 12 trainers made presentations during the course so that they were all able to stay current on the foundational materials that they had learned during the PSEP – Canada program.

In addition, the 12 PSEP – Canada trainers collaborated to develop an orientation program for new staff on patient safety.

## **Lesson learned**

Don't wait for executive sponsorship — do something right away so that you don't lose the power of fresh ideas.

## **Maintaining momentum**

Julie and her colleague Liane were among the first participants in the PSEP – Canada program. Their goal was to make the process of spreading patient safety knowledge and expertise efficient and cost effective by offering a provincial level PSEP – Canada program.

The timing was good; the province had recently committed to supporting patient safety initiatives so funds were readily available. They were both in positions of some influence and were, therefore, able to easily approach all of the provincial Health Authorities with a plan.

The first step in their strategy was to determine who would be the key people to invite to the first provincial PSEP – Canada program in the province? Who would take the knowledge learned and spread it further? They wanted to build capacity at the program level so they decided to, very intentionally, invite participants that represented the vast array of programs offered in the province.

Prior to attending the training, they asked participants to develop a plan to share their knowledge and expertise following their attendance at the PSEP –Canada provincial training. Julie and Liane wanted to make sure that the participants stayed engaged in the process following the education so they sought VP level support. The VP was asked to meet with all of the participants to follow-up on progress made on individual plans following the training. They also put together a provincial forum for PSEP – Canada trainers to attend on a bi-monthly basis.

The forum identified two streams of response to patient safety issues: the system stream and the local stream.

At the systems level, a Safety Network was established to consider and develop patient safety goals and objectives and to establish policies to support local initiatives. Systems level support was more difficult to establish and took some time to launch. At the systems level, senior level support was required to move the program along efficiently. Unfortunately, the PSEP – Canada trainers were not able to transfer their level of passion for the issues to those that needed to make patient safety education a priority across the

system. As a result, at the systems level, the system was not ready to implement all that the PSEP – Canada trainers had to offer.

Fortunately, the systems level delay did not stop the PSEP – Canada trainers from doing what they could at the local level. The local level did not wait for systems level support. They went ahead with supporting local initiatives so that momentum was not lost among the PSEP – Canada trainers. Their bi-monthly forum meetings provided an opportunity to share their experiences and address challenges.

## **Lessons learned**

To maintain momentum, PSEP – Canada trainers should use the tools that they have been provided with to begin patient safety training at the local level—the level where they have some control. If Julie and Liane had waited for policies and procedures to be put into place at the corporate level, momentum may have been lost.

Large organizations are complex and a great deal of pre-planning is required to get an organization ready for patient safety education. While working on local initiatives, PSEP – Canada trainers need to find champions at the executive level who can move the patient safety policies forward so that trainers are encouraged and supported to deliver patient safety education locally. Leaders must also provide time and back-fill support so that PSEP – Canada trainers can do the training while doing their regular day-to-day work.

PSEP – Canada trainers have been enabled to address patient safety issues at the local level and they have the tools available to them to support those education initiatives. The challenge is balancing day-to-day jobs with the delivery of patient safety education programs. Spreading their knowledge and training to others to deliver training will maintain momentum, balance the workload and spread the initiatives faster and further.

## **Prioritizing and maximizing your time**

Jean returned to her organization following the PSEP – Canada training with a very practical perspective. She knew that although everyone in healthcare thinks that patient safety is their first and foremost priority, it tends to get swept aside as the realities and rush of daily responsibilities take over. Her goal, therefore, was to take all that she had learned and see how she could integrate it into what already existed in the organization.

It was true that patient safety was being addressed in a variety of ways throughout the organization. However, how could she tease it out and bring it to the forefront of everybody's thinking?

Jean's organization was flooded with education. She needed to find a way to embed the content that she'd learned into what was already happening. She did not take the PSEP – Canada education as it was taught to her. Instead she took pieces of it and was determined to integrate it into other existing programs.

Her goal was to find the champions of patient safety and link with them to make sure that patient safety education was integrated into what they were doing. She connected with the Nursing Program, the orientation program in the Human Resources department and the inter-professional education team. She also worked with medical residents in all disciplines to help them understand the importance of patient safety.

She asked to participate in a regular meeting of the nursing program to introduce the concept of medication error. During that meeting she asked for volunteers to attend a short session on how to analyze medication errors using the fishbone method. Jean also asked to be part of the falls prevention program so that she could provide a patient safety lens in the development of the program. She helped to identify the tools, education and policies that were put into place to address falls prevention however, they needed local units to take it further. A charge nurse then led the process and took it down to the unit level.

Jean also reached out to the Transportation and Operations groups to integrate patient safety content into what they were doing. She met with Information Technology, Infection Prevention and Control and the Patient and Family Centred care groups to find out what they were doing and discover how she could help them integrate patient safety education into their programs.

She joined as many committees and groups as possible to represent the patient safety perspective and made sure that it was brought to the forefront of discussions. She also joined the LEAN process improvement initiatives that were happening in the organization to make sure that processes that were being improved continued to be viewed through the lens of patient safety.

From the frontline perspective, she heard about huddles happening in the organization and she made every attempt to join those huddles to ensure that the patient safety perspective was kept on their minds.

Jean also kept her “ear to the ground” for the “hot topics” so that she could become part of those groups to inject the patient safety perspective.

From the strategic perspective, Jean identified where the topic of patient safety education fit within the organizational strategic plan so that she could refer people back to the priority of addressing patient safety issues.

She linked with both the Quality Improvement and Risk Management groups that were working proactively to prevent issues from becoming threats. She made every effort to determine how patient safety education fit with those groups and how to give them the tools they needed to promote patient safety.

Through all of this involvement, Jean gained a reputation as a patient safety expert and was invited to join the learning institute as they developed a simulation program that was being developed to make sure that patient safety was part of the program.

## Lessons learned

Jean found that she could not do patient safety education in isolation. She felt that if it was done without the follow-up support required to carry-out the initiatives, the education would not be successful. She was determined, therefore to work with others who were doing quality improvement, risk management and LEAN initiatives to make sure that patient safety was brought to the surface and integrated into what was happening throughout the organization.

Jean became an advocate for patient safety by joining any and all existing groups; she made her voice heard. She wasn't able to use what she'd learned at PSEP – Canada exactly as it was delivered however she took what she had learned and integrated it into as much of her organization's existing programs as possible.

It is important for PSEP – Canada trainers to not worry about implementing the curriculum in its entirety. Recognizing what is already happening in organizations and finding ways to integrate patient safety education into those programs will help prioritize patient safety in the thoughts and actions of all people working in an organization.

## From theory to practice

Slide 7

### From theory to practice

- The Dixon 6 methodology
- Stages of education impact and change

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Slide 8

### Stages of education impact and change

- Attitudes/precontemplation (Relevance, data)
- Knowledge/contemplation (What tool can help?)
- Skills/preparation (Practice)
- Behavior/action (Implementing the tool)
- Patient experience/outcome of action
- Societal norms/maintenance

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Given the experiences of PSEP – Canada trainers, it is critical to understand what is needed to effectively transfer PSEP – Canada learning to health care organizations so that the learning results in an improvement in patient safety practices.

According to the Dixon 6 theory of stages of education and impact shown above, it takes six steps for a learner to apply theory to practice. (Dixon 1978)

All learners begin with an attitude about a particular topic. Perhaps something has triggered that attitude; for example, an experience with a patient safety incident. The attitude opens the mind to discovery—to learning more about the topic.

The second step is acquiring the knowledge needed to fully understand the new topic. This step provides the depth of understanding about the topic, it is the knowledge acquisition step of the process.

Step three is when the learner acquires the skills to put new knowledge into practice. They are either taught the skills or they test skills needed to apply the knowledge in a real setting.

Step four is when, as a result of applying the knowledge, behaviour changes. Learners not only have the understanding (attitude and knowledge), they also know how to put the knowledge into action through skills which then change behaviour. The skills are applied in the workplace.

The fifth step is the outcomes that are revealed as a result of a change in behaviour. Having changed the way that you are doing things you now see results that are measurable.

The sixth step is that the behaviours have become norms because evidence has proven that the theory works when it is put into practice. The practice, based on the theory is now operationalized into everyday behaviour. It is a norm shared by all.

To reiterate, the Dixon 6 theory suggests that there is an evolution to successfully translate theory into practice. Attitudes and knowledge do not change behaviour but they must come before learning how to apply new knowledge. Once learners have learned the skills needed to apply the knowledge there will be a shift in behaviour which will result in desired outcomes. For the behaviour to become operationalized the outcomes must be positive. When that happens and a group of learners achieve the desired outcomes on a consistent basis then the practice becomes a norm among a community resulting in community- wide improvement.

# Leveraging change

Slide 9

## Leveraging change



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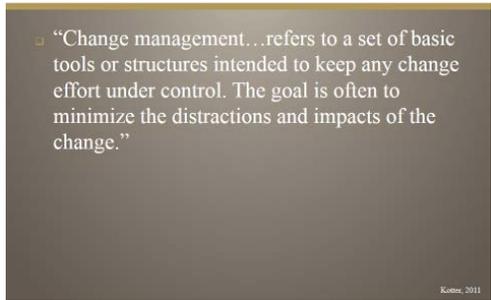
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Embedding a culture committed to patient safety requires a Change Management strategy.

## What is change management?

Slide 10

## What is change management?



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According to John Kotter, "Change management...refers to a set of basic tools or structures intended to keep any change effort under control. The goal is often to minimize the distractions and impacts of the change." Kotter states that change management refers to using a structured process to make sure that change initiatives are successful and sustainable. (Kotter 2011)

# Kotter's 8 step process

Slide 11

## Kotter's 8 step process

- 1. Create urgency
- 2. Form a powerful coalition
- 3. Create a vision for change
- 4. Communicate the vision
- 5. Remove obstacles
- 6. Create short-term wins
- 7. Build on the change
- 8. Anchor the changes in corporate culture

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There are many theories about how to manage change, many of which originate from John Kotter's leadership. Kotter is a professor at Harvard Business School and a world-renowned change expert. His eight-step change process is outlined in his 1995 book, "Leading Change." The 8 step process continues to be one of the most famous and widely-used strategy across all sectors.

The 8 steps to manage change include:

1. Create urgency
2. Form a powerful coalition
3. Create a vision for change
4. Communicate the vision
5. Remove obstacles
6. Create short-term wins
7. Build on the change
8. Anchor the change in corporate culture

## Step 1: create urgency

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### 1: Create urgency ...



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According to Kotter, the first step to effective change management is to “create urgency.” As mentioned earlier, planning is critical to the effective implementation and sustainability of patient safety education in health care organizations. In the case of

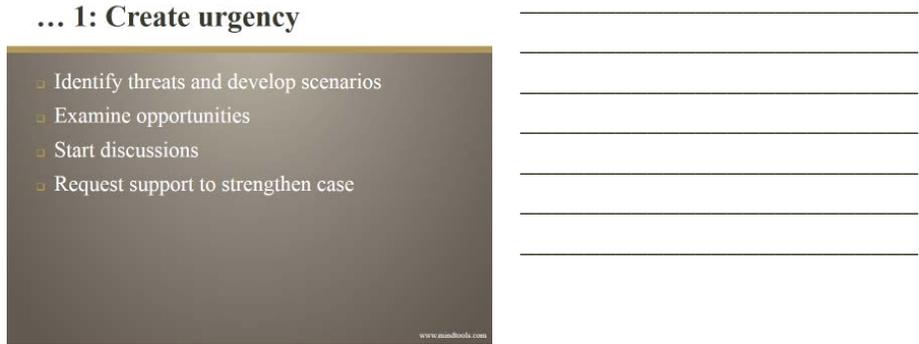
Kotter's Change Management theory, that planning begins by spending time developing a sense of urgency in organizations.

**Given the importance of this first step, what is needed to create urgency?**

Slide 13

**... 1: Create urgency**

- Identify threats and develop scenarios
- Examine opportunities
- Start discussions
- Request support to strengthen case



For change to happen, people must feel the need for change. A sense of urgency at the most senior levels of the organization is critical as it is at every other level of the organization. How do you incite passion for the importance of patient safety education so that adequate support is found to incite a desire for change?

If a sense of urgency builds, it will spread throughout the organization. Many people will begin talking about the desired change and the urgency will build.

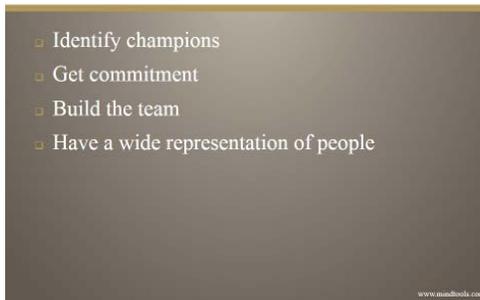
Here is what you can do:

- Identify potential threats in your organization (for example, hospital standardized mortality ratio (HSMR) rates, hand hygiene audits, infection control rates) and develop scenarios showing what could happen in the future.
- Examine opportunities that should be, or could be, exploited.
- Start honest discussions, and give dynamic and convincing reasons to get people talking and thinking.
- Request support from leaders, patients, clients, and outside stakeholders to strengthen your argument.

## Step 2: form a powerful coalition

Slide 14

### 2: Form a powerful coalition



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The second step of Kotter’s 8 steps to manage change effectively involves getting others onboard to support the change initiative or engaging others. This requires convincing people that change is necessary. This often takes strong leadership and clearly visible support from senior leaders in an organization. Managing change has to be led. Effective change leaders can be found throughout your organization, not necessarily only in formal positions of authority. Leaders are people with influence. Look for those people in your organization, at every level, that have “influence” over others and invite them to participate in a patient safety coalition.

The leaders without titles are part of the informal culture of the organization. They motivate others in a variety of ways and every organization has them. People look to them before they become involved in initiatives. Sometimes they are union leaders, sometimes they are at the very frontline of an organization. Consider the benefits of the proposed education. How will it make the workplace better for the workers? Consider how to convince those informal leaders why they would want to become part of a coalition. Refer to PSEP – Canada Module 8: Leadership: Everybody's Job for further information on contributions from all levels of leadership within an organization towards creating a strong patient safety culture.

Once a coalition is established, work as a team to continue to develop a sense of urgency throughout the organization.

The coalition’s activities should be formally structured including regular meetings with corresponding agendas and minutes. Require that members commit to attending all meetings and develop the group to work successfully as a team.

It will be important to get wide representation from throughout the organization so that a sense of urgency will build everywhere.

Here is what you can do:

- Identify the true leaders/champions in your organization.
- Ask for an emotional commitment from these key people.
- Work on team building within your change coalition.

- Assess your team for weak areas,
- Ensure that you have a good mix of people from different departments and different levels within your organization.

When forming the coalition, remember that this is a coalition to lead a change initiative in the organization.

Slide 15

**The power of influence**

- Leadership = influence
- Influence = relationships
- Relationships = connection
- Connection = time

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Embedding a culture of patient safety throughout an organization requires strong leadership skills. According to John Maxwell, an expert in leadership studies, the definition of Leadership is influence (Maxwell 1998). The way to get influence is by developing relationships with people and the way to develop relationships with people is by connecting with them. How can you connect with the right people? Discover the WIIF (What’s in it for me) factor for them. How can you get to know them and convince them of the importance of this initiative? Take the first step, communicate with as many people as you can, get to know them, care about them and their concerns, build relationships and then you will acquire influence. Taking that time to build relationships will give coalition members an immense amount of power. Train the coalition about the power of influence and how to influence others.

**Step 3: create a vision for change**

Slide 16

**3: Create a vision for change**

- Develop goals and objectives
- Develop a summary of the vision
- Create a strategy to execute that vision
- Ensure that your champions can describe the vision in an “elevator speech”
- Practice the “elevator speech” often

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To manage change successfully, it is very important that the coalition has a clear direction and focus. At the beginning there will probably be many great ideas and

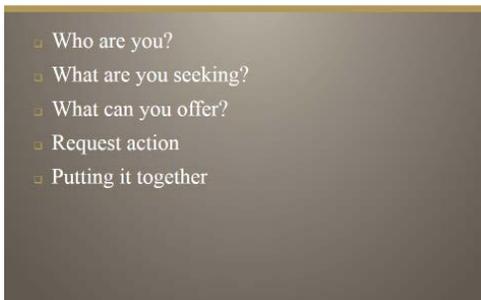
solutions floating around. Develop goals and objectives that are linked to the goals and objectives found in the organizational strategic plan. This will give the strategy credibility in the organization. What is it that you ultimately want to achieve? Knowing what you want to achieve (in the future) will help everyone understand why they are supporting the change.

Here is what you can do:

- Determine the values that are central to the change.
- Develop a short summary (one or two sentences) that captures what you "see" as the future of your organization.
- Create a strategy to execute that vision.
- Ensure that your change coalition can describe the vision in five minutes or less (see slide on Elevator speech).
- Practice your "elevator speech" often.

Slide 17

### The elevator speech



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The basic components of an elevator speech include the following:

- Who are you?
- What are you seeking?
- What can you offer?
- Request action?
- Putting it together

An example of an elevator speech for coalition members could include the following messages:

*We want to work in an organization that cares about and understands patient safety.*

*We are learning more about the importance of spreading best practices throughout an organization to embed safer care.*

*Commitment to patient safety is a shared responsibility. Everyone reaps the benefits of safe health care; everyone suffers when health care is unsafe.*

*The more people that are educated on patient safety issues and strategies, the more likely we are to prevent patient safety incidents from happening.*

*Our patient safety survey results indicate that \_\_\_\_% of staff know about patient safety.*

*We are becoming more and more accountable for patient safety through Accreditation requirements and ROPs, provincial reporting and to patients and their families.*

*Our families are indicating that: (take from patient satisfaction surveys).*

*We have formed a Patient Safety Education coalition made up of representatives from throughout the organization. We have a goal to teach the entire organization about patient safety.*

*We need your support to move forward with this initiative. What can you do to help us?*

Note: this example includes the basic components of an elevator speech. It should be no longer than about 90 seconds.

## Step 4: communicate the vision

Slide 18

**4: Communicate the vision**

- Talk often about your vision
- Address concerns and anxieties
- Tie everything back to the vision
- “Walk the talk”

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After the vision is developed, it needs to be communicated consistently throughout the organization. What is done with the vision after it is created, will determine success. It is important that everyone in the coalition is giving the same message. That message will then be repeated throughout the organization and will gain strength. The message could be the elevator speech. It will become monotonous to those relaying the message but it is critical that it is repeated often because there will be competing messages happening

throughout the organization. The more that it is heard, the more momentum it will gain. Communicating the vision doesn't require special events or meetings to make an announcement. It simply needs to be talked about as often as possible both formally and informally—don't wait for special occasions. Keep it on the top of people's minds by communicating it frequently. Furthermore, demonstrate the patient safety behaviour that is recommended through the change initiative: “walk the talk.”

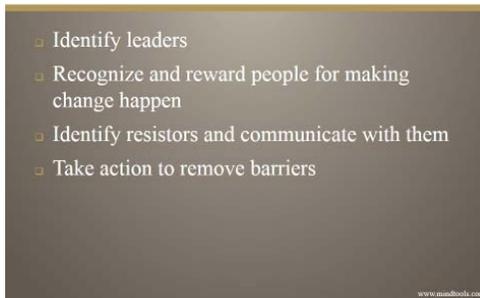
Here is what you can do:

- Talk often about your change vision.
- Openly and honestly address peoples' concerns and anxieties.
- Apply your vision to all aspects of operations – from training to performance reviews. Tie everything back to the vision.
- Lead by example.

## Step 5: remove obstacles

Slide 19

### 5: Remove obstacles



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At step 5, change initiators should be looking and listening for resisters to change. Who are the biggest “naysayers” that may be generating resistance to change? There will always be resisters, it is important to look for them and put their negativity to rest. If it is at the very senior level, a presentation will be required that convinces executives of the value for Patient Safety Education. If the resisters are at the middle or lower levels of the organization where you are hearing “been there, done that” or “there is no way that that will happen here; the leadership will never allow it to happen” then it will be important for those comments to be addressed. One suggestion is to speak to those people and inquire about their concerns, ask them about their ideas of how to make the change happen. Perhaps welcome them to join the coalition (only if they are leaders [informal or formal] with influence). If they are seen as negative people who the rest of the organization ignores, it would be better to ignore them. If members of the coalition are negative they should be asked to leave the coalition because they will halt the efforts of the coalition.

Here is what you can do:

- Identify change leaders whose main roles are to deliver the change.

- Recognize and reward people for making change happen.
- Identify people who are resisting the change, and help them see what's needed.
- Take action to quickly remove barriers (human or otherwise), but remember to consider the possible consequences of those actions before you act!

Slide 20

**Presentation to leadership**

- Building the business case for patient safety education
  - the evidence
  - accountability responsibilities
    - Accreditation and Required Organizational Practices
    - provincial regulations
    - recommendations from reports

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Slide 21

**The evidence**

- # of patient safety incidents/per year compared with provincial and federal averages
- Cost of patient safety incidents/per year compared with provincial and federal averages
- Patient Safety Culture survey results
- Patient Satisfaction survey results
- Staff Satisfaction survey results

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Removing barriers may include going back to the leaders of the organization to get their re-commitment to support patient safety education in the organization.

Leaders will be reluctant to invest time and energy in anything that has a cost associated with it. For example, if the patient safety education program is going to take employees out of their regular jobs to receive the education, there is a cost to back-fill their positions.

Leaders must, therefore, be convinced about the greater cost of not investing in organization-wide patient safety education. It will be very important to build a business case for senior leaders.

The business case should include:

- the evidence,
- accountability responsibilities:
  - Accreditation and Required Organizational Practices (ROPs),
  - Provincial Regulations, and

- Recommendations from reports.

A number of indicator results could be included as evidence for the business case including:

- # of patient safety incidents/per year compared with provincial and federal averages;
- cost of patient safety incidents/per year compared with provincial and federal averages;
- Patient Safety Culture survey results;
- Patient Satisfaction survey results; and
- Staff Satisfaction survey results.

Slide 22

**Briefing note**

- Background information on the issue
- The current situation on the issue in the organization
- Recommendations to consider
- Possible results of the recommendations

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A briefing note is an effective way to deliver the information included in a business case to an executive team. Presenting the briefing note to a champion leader provides a convenient method for them to bring it forward to the senior leadership team. A briefing note should contain:

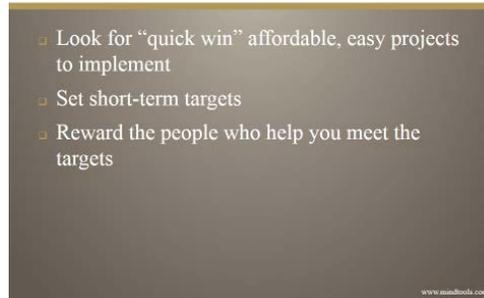
- background information on the issue: link to vision, mission and values,
- the current situation on the issue in the organization,
- recommendations to consider, and
- potential results of the recommendations.

Briefing notes are not very long and individual organizations may have standard templates.

## Step 6: create short term wins

Slide 23

### 6: Create short-term wins



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Nothing motivates people more than achieving some success. The coalition should look for opportunities to get some “quick wins.” Some ideas may be to invite staff to attend “lunch and learns” on patient safety. During those lunch and learns presenters could ask attendees to share stories and experiences about their concerns for patient safety. Presenters could then choose one or two of the scenarios that come up in the discussion and walk participants through a fishbone exercise or a “5 Why’s” exercise. This will demonstrate tools to analyze patient safety incidents and show how to put improvements into place.

The coalition will need to make sure that when the “lunch and learns” are advertised, people know the purpose and benefits of the training. Lunch and Learn’s should be planned to take place over about 45 minutes. They should not be lengthy and should not include too much information. One topic at a time is sufficient to providers learners with one or two tools to use when they return to their jobs. It is better to have them leave wanting more information than to have them leave thinking that it went too long.

It is important to set targets to achieve those short term wins, for example, decide to do 3 “lunch and learns” every quarter.

Here is what you can do:

- Look for sure-fire projects that you can implement without help from any strong critics of the change.
- Don't choose expensive targets. You want to be able to justify the investment in each project.
- Thoroughly analyze the results of the projects. If they don't succeed, consider why. Did enough people know about them? Did you have the right person facilitating the session? If it goes badly, it can hurt your entire change initiative so carefully consider the project through.
- Reward the people who help you meet the targets.

## Step 7: build on change

Slide 24

### 7: Build on the change

- After every success, analyze results, what still needs improving?
- Set goals to continue building on the momentum
- Embed patient safety education into quality improvement activities
- Continually involve new people and leaders in your change coalition

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In your weekly, bi-weekly or monthly meetings with your coalition, take the time to analyze what is happening with the plan. What is working well and what is not working? What do you need to improve? What do you need to do to maintain momentum? Is there anyone else that you need to involve in order to generate more “quick wins?”

Kotter argues that many change projects fail because people get excited too soon over “quick wins.” Real change takes time and many change initiatives. Quick wins are only the beginning of change intended to get the momentum going. They need to continue over a long period of time and build on the success of previous initiatives. Organizations need to continually look for improvement opportunities.

Here is what you can do:

- After every win, analyze what went right and what needs improving.
- Set goals to continue building on the momentum you've achieved.
- Embed patient safety education into quality improvement activities.
- Keep ideas fresh by involving new people and leaders in your change coalition.

## Step 8: anchor the changes in corporate culture

Slide 25

### 8: Anchor the changes in culture

- Talk about progress constantly
- Include the change values in education when hiring and training new staff
- Publicly recognize your champions
- Create plans to replace champions

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To make the change sustainable, it needs to become part of the culture of an organization. Corporate culture determines what gets done. It is critical, therefore, to make sure that initiatives are linked to the corporate vision. Make continuous efforts to ensure that the

change is seen in every aspect of the organization. Write articles for an internal newsletter including results that are heard about and seen as a result of the education. Create posters on patient safety initiatives. Advertise patient safety learning events e.g., lunch ‘n learns. This will help ensure that the change is operationalized. It is also important that senior leaders continue to support the change. If that support is lost, the coalition might end up having to start over again from square one.

Here is what you can do:

- Talk about progress every chance you get. Tell success stories about the change process, and repeat other stories that you hear.
- Include the change ideals and values when hiring and training new staff.
- Publicly recognize key members of your original change coalition, and make sure the rest of the staff – new and old – remembers their contributions.
- Create plans to replace champions as they leave the coalition. This will help ensure that their legacy is not lost or forgotten.

## The opportunities

Slide 26

### The opportunities

- How do we move from this setting to our setting?
- What are your immediate opportunities?
- What can you do with those opportunities?
- Depending on the opportunities available:
  - What content do we teach, where, when, to whom?
  - Is there a need for content?
  - Do I have the access to this group?
  - Do I have a setting to offer training?

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Translating theory into practice requires taking advantage of opportunities. The opportunities that lie beyond the door depend on a number of factors. One factor that to consider is whether, given the reality of an organization’s situation, immediate opportunities can be identified. Another factor would be how a culture committed to patient safety can be developed and sustained.

For many organizations fiscal restraint is a constant reality and spreading PSEP – Canada will require creativity, as education and development monies are frequently reduced during periods of fiscal restraint.

It can be difficult to find time to allocate for a Quality Improvement team meeting to discuss patient safety initiatives, and so the team may need to assess those needs.

If the staff cannot leave their unit/area, one way to reach them may be a five minute huddle to focus on one aspect relevant to an area. There may also be other

opportunities for fitting into the work/action plan (which helps provide sustainability and accountability).

When planning the meetings, consideration should be made as to any need for content, as well as where, when and to whom will it be offered.

## Engage others

Slide 27

**Engage others**

- Get the frontline involved, have them share stories and identify priorities
- Share results
- Involve physicians in the training
- Reward those initiators

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A number of steps should be followed to engage others in an organization in patient safety education. According to a study entitled, “Engaging Clinical Nurses in Quality and Performance Improvement Activities” published in *Nurse Admin Q*, Vol. 34, No. 3, pp. 226–245, 2010. “Clinical nurses should have a voice in identifying priorities and selecting nursing sensitive patient outcomes to evaluate the impact of nursing care” (pg. 231). This study found that, “Patient care can become so routine that direct care nurses may not think about the quality of care they provide to patients on a daily basis. Perceptions of quality care are important to nurses, and nurses may feel dissatisfied with their work and experience stress when they are unable to deliver quality care. (pg. 243).” It is therefore critical to get nurses involved in identifying patient safety priorities and then inform them of the results of the initiatives.

According to another study it is critical to involve senior physicians in the delivery of patient safety Education for it to become a priority in the delivery of health care to patients (Ahmed et al, 2013).

Education is only one part of sustaining patient safety best practices in an organization. In order to ensure that the results of the education are sustainable, other practices must be put into place. For example, in a study reported in the *Joint Commission Journal on Quality and Patient Safety* in 2012, organizations must reward staff when patient safety issues are addressed and mitigation plans are put into place. In this report, health care workers were rewarded with “good catch” rewards for effective mitigation plans that are put into place (Herzer, Mirrer, et al 2012).

# What are your opportunities?

Slide 28

## What are your opportunities?



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Research is showing that sustainability of quality improvement and patient safety initiatives continues to be a challenge in health care organizations. According to an American study done in 2012, adverse events are still happening much too frequently (Glasgow, Davis and Kaboli, 2012).

Thorough planning is critical and a commitment to preparing the organization for the PSEP – Canada program is required. The literature supports that for initiatives to be sustainable, they must be leadership driven. A senior level champion must be found that will support the Patient Safety cause. He or she must acquire a sense of urgency needed to move the issue to the forefront of thinking at the executive level and to support patient safety initiatives. The senior level champion is necessary to support and drive all of the initiatives. That person needs to be seen as “the person in charge.” That person will make sure the projects happen and will be accountable if they don’t happen. They need to make sure that communications occur to effectively move the program at the senior level and to reward those that are making it happen (Compas, 2008)

PSEP – Canada trainers can begin with the action plan that they develop at the end of the PSEP – Canada program. They should arrange to meet with senior leaders as soon as possible when they return home to discuss how to transfer the learnings gained from the PSEP – Canada program to active learning in the organization.

In addition, PSEP – Canada trainers need to sustain their own passion for what they have learned in the program. To get the project going, they could form a coalition/collaborative with other PSEP – Canada trainers to meet regularly to share initiatives, results and challenges.

PSEP – Canada trainers will need to make an effort to become “known” in their organizations as Patient Safety experts. One way this can be achieved is by joining as many active committees and programs as possible and by becoming the spokesperson for patient safety on those committees.

As advocates for patient safety, PSEP – Canada trainers could use their expertise to ensure that the topic of patient safety is integrated into all education that is delivered throughout the organization. This is a viable option to creating a separate patient safety

education program. This will make the education relevant to those receiving it which is a hallmark of successful knowledge transfer (Fineout-Overholt, 2010). PSEP – Canada trainers should also remember to become involved with the “hot topics” within their organization for example LEAN initiatives and inter-professional care projects, to embed patient safety thinking into all improvement projects.

To begin the knowledge transfer process, PSEP – Canada trainers can also develop a program that can be customized and delivered throughout the organization. This could be in the form of an introductory program that is shared to introduce the topic of patient safety in a brief but meaningful way to any audience.

## Summary

Slide 29

### Summary

- ❑ Create a sense of urgency
- ❑ Knock on the door of opportunity
- ❑ Be prepared for when opportunities for change present themselves

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The first step to change is to get others to open the door but before they open the door you need to knock on it. Determine how you are going to get others to open the door when you start knocking. Remember to create that sense of urgency so that they will want to open the door.

Alexander Graham Bell has been quoted “When one door closes another opens, but we often look so long ... upon the closed door that we do not see the one which has opened for us”.

## Potential pitfalls

Slide 30

### Potential pitfalls

- ❑ Don't wait for the perfect opportunity
- ❑ Don't wait for leadership support before you do anything

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1. Do not wait for the perfect opportunity to implement a change
2. Do not wait for leadership support before you do anything - find ways to integrate patient safety education into already established processes and programs

## Pearls

Slide 31

### Pearls

- Do create a sense of urgency
- Do start talking about the need for education
- Do start by forming a coalition/ collaborative

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1. Do create a sense of urgency for the change
2. Do start talking about the need for education
3. Do start by forming a coalition/collaboration

## Resources

- **Kotter’s interviewed about the importance of creating urgency, 10 minutes** [http://www.youtube.com/watch?v=zD8xKv2ur\\_s](http://www.youtube.com/watch?v=zD8xKv2ur_s)
- **Kotter talking about the importance of creating a sense of urgency, 5 minutes.** <http://www.youtube.com/watch?v=RpSI4-ZuegE&list=TLJ-NBOjfVbv4>
- **Learning from Error - video and booklet: long video on how errors happen in hospitals:** Accompanying training workbook learning from error found in “resources.” [http://www.who.int/patientsafety/education/vincristine\\_download/en/index.html](http://www.who.int/patientsafety/education/vincristine_download/en/index.html)
- **The World Health Organization:** The WHO has a wealth of resources to access including posters and teaching materials to educate others about patient safety. <http://www.who.int/patientsafety/en/>
- **Talking to Your Colleagues:** In South Carolina, they made a special effort to put the Safe surgical checklist into place and this website has a wealth of resources. <http://www.safesurgery2015.org/talking-to-your-colleagues.html>
- **BC Patient Safety & Quality Council Culture Improvement Resources:** BC website with a wealth of resources for Quality and Patient Safety Education. <http://bcpsqc.ca/clinical-improvement/teamwork/resources/>
- **Impact BC Common Quality Improvement Concepts:** A BC website with a wealth of resources for QI learning. <http://www.impactbc.ca/resources/qi-concepts>
- **Sustainability Model and Guide:** National Health Service, England <http://ia201119.eu.archive.org/tna/20061004085342/institute.nhs.uk/Products/NHSSustainabilityModelandGuideStaff.htm>
- **Leadership Challenges of Quality in A Tough Financial Environment:** Jim Easton, National Director for Improvement and Efficiency, National Health Service, England <http://bcpsqc.ca/documents/2012/11/Tackling-the-Cost-and-Quality-Imperative-Jim-Easton-National-Director-for-Improvement-and-Efficiency-Department-of-Health-UK.pdf>

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- Maxwell JC. *The 21 Irrefutable Laws of Leadership: Follow Them and People Will Follow You.* Nashville, USA: Thomas Nelson Publishers; 1998

### Principal message

The single most important message that your audience should come away with is that *successful transfer of the knowledge and learning acquired from the PSEP – Canada program requires discovering where and how the learning can be applied most efficiently and effectively in each organization.* The participant should also come away with an understanding of what is required to implement a change initiative successfully.

### Module overview

PSEP – Canada graduates often encounter frustrations when it comes to transferring what they have learned in the PSEP – Canada conference to their own organizations. The goal of this module is to help PSEP – Canada trainers determine what they will need to do when they return to their organizations to start spreading their patient safety knowledge throughout the organization. This module focuses on Change Management Theory and how to apply it to successfully transfer PSEP – Canada knowledge to organizational operations.

### Preparing for a presentation

#### 1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

#### 2. Presentation timing

The suggested timing for each part of this module is:

Introduction	5 minutes
The Challenges	10 minutes
Change Management Theory	30 minutes
Opportunities	10 minutes
Summary	5 minutes
Total	60 minutes

### 3. Number of slides: 31

#### 4. Preparing your presentation

The first part of this presentation is told in story format, recounting the experiences of 3 PSEP – Canada trainers and the barriers they encountered when they returned to their organizations to implement what they had learned at the PSEP – Canada conference. The intention of the stories is to provide real case scenarios of what PSEP – Canada graduates may encounter and provide ideas to overcome the potential barriers. Stories have proven to be an effective method of capturing the attention of learners and are much more likely to be remembered than the relaying of facts and figures.

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content and your own personal style.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

#### 5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP – Canada Front Cover Page;**
- **PSEP – Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic;** and
- appendix material as relevant.

#### 6. Equipment needs

- Computer
- Projector and screen
- Internet access to Youtube

- Sound system or speakers connected to your computer for the Youtube video

Test your equipment beforehand to ensure that it works.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if you don't have access to Youtube, you can skip this slide; and
- if the slides cannot be shown, you can refer to the hand-out slides

## **Making the presentation**

### **1. Introduce yourself**

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

### **2. Introduce the topic**

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of the topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

### **3. Review the session objectives**

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

### **4. Present the material**

#### **Recommended style: presentation and case-based teaching**

This module provides three scenarios to set the context for the rest of the presentation. The scenarios will permit you to engage your audience through story-telling, while allowing you to cover the material within the time permitted. To foster interaction, you could ask participants for examples from their institutions or from their own experiences. For example: How are you going to provide your executives/managers with an overview/ key messages of what you are able to provide for them and their staff?

What opportunities are there in your organization to reach this group for buy-in? (i.e. all management meetings, management training, intranet opportunities) What is the first session that you could provide education and is there an existing opportunity to link into within your organization? You could also provide examples of your own which could then be linked to the major teaching points.

## **5. Key take-home points**

1. Seek executive support to prioritize patient safety education.
2. Maintain momentum so that PSEP – Canada learning is not lost while waiting for policies and procedures to be put into place.
3. Prioritize and maximize time so that patient safety education does not become an added burden to an organization.
4. Engage others in the process of spreading patient safety education.
5. Embedding a culture committed to patient safety requires a Change Management strategy.

## **6. Summarize the discussion**

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

## **7. Debrief about the teaching method**

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

## **8. Post-test/evaluation**

Ask the participants to complete the post-test questions for this module and evaluate the session.