

Phase	Content	Time
A Introduction	<u>Eye-catcher</u>	
Activation; collective phase	<u>Case presentations:</u> Case 1: a treatment error reported widely in the media Case 2: a treatment error by a medical intern reported widely in the media Case study 3: a personal case of a treatment error; additional epidemiological information, social perception and consequences -> should illustrate the topic's significance	10 mins
B Learning break	<u>Processing:</u> Reflective question for all participants: "Make a note on a piece of paper of 1–3 errors that you personally have committed (e.g. in medicine, traffic, etc.)!"	2 mins
C	Information that these notes will be returned to later. Transitional question: how are errors defined and how do they arise?	
Collective phase	<u>Agenda + input:</u> First content block with definition of the terms error, error types and error culture. Sources of errors, favourable factors, models of error sources and risk areas.	15 mins
B Learning break/partner work	<u>Processing/consolidation:</u> Task for all participants: "Discuss the personal events you have just made a note of with your neighbour: - How would you describe these according to the definitions you have learned? - At what point did the error occur (according to the model presented)? - Categorise factors that led to errors as 'latent, conducive or active'?"	4 mins
C	Transitional question: Which strategies can be used to avoid mistakes?	
Collective phase	<u>Input:</u> Second content block with the topics of systematic error analysis, measures to enhance patient safety through strategies to avoid treatment errors (especially surgical mixups and medication errors), presentation of projects to enhance patient safety (particularly error reporting systems such as CIRS).	15 mins
B Learning break/partner work	<u>Processing/consolidation:</u> Task for all participants: "Continue to discuss your personal experiences with your neighbour: - Which measures might have prevented the errors from occurring?"	4 mins
C	Voluntary report on participants' personal experiences	2 mins
D Conclusion	<u>Summary</u> <u>Outlook for the coming trimester:</u> 1. PBL case on patient safety	5 mins

	<p>2. Formulation of observation tasks for the coming trimester:</p> <ul style="list-style-type: none"> - Observation task during the bedside teaching in anesthesiology in the operating theatre: "Which of the strategies presented were experienced?" - Debriefing/report about it before/after the simulator seminar on anesthesia 	
Evaluation	"One-minute paper" evaluation: students should make a note of a positive aspect on a white card and a point in need of improvement on a blue card as anonymous feedback.	3 mins
	Total	60 mins