

Patient safety in an interprofessional learning environment.

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Horsburgh M, Merry A, Seddon M. Patient safety in an interprofessional learning environment. Med Educ. 2005;39(5):512-3.

<https://psnet.ahrq.gov/issue/patient-safety-interprofessional-learning-environment>

The authors discuss a patient safety–focused, shared learning program developed by the medical and health faculty at the University of Auckland. Faculty of the program used [root cause analysis](#) to illustrate that underlying failures in a system can lead to individual error.