Results: A structured, evidence-based methodology based on the hospital mortality review program provided an effective framework to teach patient safety. Resident engagement was facilitated by using real morbidity and mortality cases.

Conclusions: Mortality review programs offer an opportunity to train residents on principles of patient safety and high reliability. A clinical triggers methodology that measures and tracks adverse events provides a framework to deliver the content using a case-based and interactive format.

FINAL WORK PLAN – Florida Hospital

Team Charter/Objectives	In a collaboration between the GME and the Performance Improvement departments, the main focus of our project was to develop an effective patient safety curriculum for faculty and residents using a comprehensive mortality learning program for the hospital as a framework.
Project Description	The curriculum was divided into 4 phases: (1) 3 modules on the study of medical errors, the science of human error, and principles of high reliability; (2) review of training charts using a clinical triggers methodology; (3) review of the real case using the tools and format of the Florida Hospital Mortality Review Program; and (4) a mortality and morbidity presentation to the resident group.
Vision Statement	Residents at Florida Hospital will acquire the skills, knowledge, and attitudes necessary to become leaders in the development and implementation of initiatives that mitigate patient harm and advance a culture of high reliability in healthcare.
Success Factors	The most successful component of our work was engaging faculty and residents in a patient safety curriculum. We were inspired by institutional commitment to advancing a culture of patient safety and high reliability.
Barriers	The largest barrier we encountered was a lack of familiarity with the implications of patient safety for the medical profession. We worked to overcome this lack of knowledge by discussing the implications of patient safety for not only the patient but also for the healthcare system and for the individual doctor's practice.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Institutional support and getting buy-in from residents and faculty are critically important.

Regions Hospital[1]/HealthPartners Institute for Education and Research,[2] St. Paul, MN

"Good Catch" Safety Event Reporting

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Background: One of the 6 focus areas of the CLER program is patient safety, specifically patient error reporting. Teaching institutions need to ensure that residents have the opportunity to report errors, unsafe conditions, and near misses and then participate in safety event analysis, action plan development, and follow-up. Unfortunately, early reports from ACGME CLER visits have shown that many institutions fail to engage residents in this process. At the same time, residents may not be aware of why or how to report patient care errors. Even if they are aware, they may be hesitant to report errors for fear of retribution or because of time constraints.

Methods: We created a multidisciplinary work group involving key Regions Hospital leaders in nursing, quality improvement, patient safety, finance, informatics, GME, and residency programs. We integrated an event reporting system into our EMR. We presurveyed residents to obtain baseline levels of awareness, ease, and comfort with safety event

reporting. We developed a 14-minute "Good Catch" event reporting video to explain the need to report, how to report, and what happens after errors are reported. The video was distributed to all 6 primary residency and fellowship programs at our institution and to all 17 affiliated programs. We postsurveyed residents after 3 months to assess their understanding of safety event reporting and to quantify how many times they had reported an event.

Results: Seven percent (8 of 112) of residents had reported an unexpected event at our institution prior to implementation compared with almost 13% after. Fifty-nine percent (66 of 112) were unsure if the reporting process was anonymous prior to implementation compared with 23% after. Seven percent of residents still didn't feel comfortable reporting unexpected events compared with 11% prior to implementation. Ninety-three percent of residents felt good about their ability to report an unexpected event after implementation compared with 41% prior. The most common reasons cited for not reporting were not knowing how to report, not wanting to take the time to report, and uncertainty regarding anonymity.

Conclusions: Resident physicians are more likely to report safety events after integration of reporting systems into the EMR and after being educated about why they need to report, how to report, and what happens after they report errors. Short, online instructional videos can be effective tools for educating residents about event reporting.

FINAL WORK PLAN – Regions Hospital/HealthPartners Institute for Education and Research

Team Charter/Objectives	Our goal was to increase the awareness of safety events and to increase the number of safety events reported by resident physicians.
Project Description	Regions Hospital and the Institute for Education and Research conducted a gap analysis to identify innovative solutions to be fully prepared for a CLER visit. The vision was to align operations with GME, and the team decided to focus on 2 areas: error reporting and integrating residents into hospital quality initiatives.
Vision Statement	By March 2015, the training video will be released and surveys will indicate increased awareness and error reporting. Rollout to faculty and other members of the healthcare team will occur. A database of hospital and resident quality improvement projects will be created, training modules will be developed and available, quality improvement resources (statistician) will be available to residents, all leading to increased resident involvement in hospital quality improvement initiatives. GME leaders will present resident quality improvement statistics at quarterly hospital leadership meetings. Upon completion of the NI IV project, this project team will merge into the Learning Environment Committee to assess CLER focus areas in an ongoing manner. Both of these projects will be monitored under this new committee.
Success Factors	The most successful component of our work was achieving full collaboration with our hospital operations partners. This project allowed each party to benefit from the results; it wasn't just a GME project with hospital operations members participating. We were inspired by how willing every individual was to carry out the project and by how willing each one was to continue participating by joining our Learning Environment Committee.
Barriers	The largest barrier we encountered was engaging our affiliate residents. They make up two-thirds of the trainees at our institution and may only spend 1 or 2 months at our hospital. We worked to overcome this obstacle by engaging the site coordinators and site directors and by working with their sponsoring institutions to help increase awareness.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Engage hospital leadership early, prior to the project start. Our DIO and assistant DIO did a great deal of work to ensure that GME was on the radar of hospital leaders and that GME leaders were at the table with hospital leadership. GME leadership also listened to ideas, incorporated ideas, and made sure everyone invited to the table felt that the project would benefit their patients, institution, and organization in one way or another. This approach helped pave the way for collaboration on this project and will help for future projects as well.