Main Line Health System, Wynnewood, PA

Walk the Talk for Patient Safety: Integrating Residents in the Organization's Patient Safety Culture

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Background: Patient safety training at Main Line Health (MLH) has evolved over time. Error prevention tools now focus on verbal communication tools that enhance best safety behaviors. In addition, the CLER visit highlighted the need for medical residents at MLH to both learn and to become integrated in the culture of patient safety.

Methods: MLH created an event called Walk the Talk for Patient Safety. Residents were invited to staff the booths at the event at our major teaching hospital, Lankenau Medical Center. The error-prevention tools we used included STAR (Stop-Think-Act-Review), SBAR (Situation-Background-Assessment-Recommendation), ARCC (Ask a question–make a Request–voice a Concern), Stop the Line, Got your Back, and 3-way repeat-back and read-back. This activity was designed to create visibility for residents as active participants in patient safety leadership while compelling residents to become completely familiar with the language of patient safety and the MLH patient safety structure. Residents were asked to complete an anonymous questionnaire to assess knowledge about patient safety and opinions about Walk the Talk for Patient Safety before and after the event.

Results: Staffing the booths provided an opportunity for residents to teach other residents and attendees about error reporting processes and procedures. After implementing Walk the Talk, 88.2% of resident respondents could name 3 error prevention tools used at MLH compared with 62.7% before implementation (P=0.002). Before Walk the Talk, 43.5% of residents (P<0.0001) disagreed with the statement "I feel confident that I know what the MLH error prevention tools are" compared to 8.9% after. The number of residents who strongly agreed that Walk the Talk is a good way to learn about patient safety tools increased from 28% prior to the event to 48.5% after the event (P<0.013).

Conclusions: Taking a leadership role in Walk the Talk for Patient Safety led to increased knowledge of patient safety topics and demonstrated that residents are involved in the patient safety culture of MLH.

FINAL WORK PLAN – Main Line Health System

Team Charter/Objectives	Our team's goals were to (1) improve the culture of patient safety at MLH, (2) better train qualified physician leaders in patient safety competencies, (3) provide an interface between residents and administration surrounding patient safety concerns, (4) identify and close the gaps between system-level and residency/fellowship program–level patient safety initiatives, (5) provide a forum for interdisciplinary collaboration among residencies and fellowships, and (6) create a standing core curriculum series at the institutional and program level that is both informational and hands on for the trainees.
Project Description	MLH established a Resident Patient Safety Council comprised of a resident or fellow member from each program in the system. Residents currently encounter and often solve patient safety concerns on a local level but would benefit from system-level collaboration to identify problems and provide practical solutions. The council participated in development of core curriculum and a Walk the Talk for Patient Safety event. The council facilitated the 6 charter/objectives listed above.
Vision Statement	Senior management and residents/fellows, with the support of GME mentoring and interfacing, will align initiatives and resources to improve the patient safety culture at MLH. Ongoing projects will stimulate faculty/trainee engagement in event recognition and reporting as well as improved standardized curricula elements for patient safety. Scholarly activities surrounding patient safety will occur at local, regional, and national forums.
Success Factors	Residents showed statistically significant improvement in their knowledge of patient safety tools from pre to post intervention. They statistically significantly felt more confident that they knew the MLH error prevention tools postintervention and agreed that Walk the Talk was a good way to learn about patient safety. Administrators were excited to have resident involvement and are eager to actively include GME in planning future events.

Barriers	The largest barrier we encountered was having 2 geographically distinct campuses that made gathering residents across the system a logistical challenge. Faculty development is needed. Time is needed for local work, conference calls, and regional collaborative meetings. Two other barriers are resident turnover (graduation) and maintaining momentum.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Early involvement with the interdisciplinary Walk the Talk planning committee likely would facilitate resident involvement and provide more meaningful leadership roles. A booth at the event conceived by the residents would further enhance teaching and GME visibility in MLH's patient safety culture.

Maricopa Integrated Health System, Phoenix, AZ

Institutional Curriculum for Resident Engagement in Quality and Safety

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Background: Despite monthly publication of quality and safety indicators, including adverse events reported by residents, we found that faculty and residents were ill informed regarding the reporting function. Many adverse events identified by residents were not being reported. We determined that a silo structure was inhibiting our reporting efforts.

Methods: An institutional curriculum was created with a goal of didactic and experiential familiarization. We implemented and tested our theory. We initiated an interactive Jeopardy-type game for testing and validation. We conducted a PDSA cycle with self-reflection post outcomes. We used visual summaries for rapid assessment.

Results: From March 2013–February 2014, residents reported 74 adverse events. From March 2014–February 2015, residents reported 107 adverse events.

Conclusions: Educational processes can be effective if they are designed and tested using residents as a target audience to address knowledge and performance gaps. A careful PDSA rapid cycle with measured outcomes and resident participation can be used to develop an effective institutional curriculum.

FINAL WORK PLAN – Maricopa Integrated Health System

Team Charter/Objectives	Using the report from our CLER visit, we were able to identify a critical lack of information dissemination, leading to demonstration of gaps in knowledge and performance in quality and patient safety initiatives. Our team's goals were to identify those areas that have created significant gaps in knowledge and lack the participation of both our residents and many faculty.
Project Description	We determined the level of knowledge and level of engagement of our residents in these 2 areas by direct quiz or encounter. We used educational conferences to determine the preferred method of learning. Likewise, we established a benchmark for attending physician involvement. We used a cycle of PDSA to test educational tools that led to the most improved performance. We documented resident adverse event reporting before educational intervention and we will record resident reporting of these events posteducation. We anticipate a 50% increase.
Vision Statement	We will develop a systematic education and evaluation process that ensures all residents understand institutional quality and patient safety initiatives, leading to their full engagement in the processes. We envision the adoption of quality and safety parameters that measure continuous improvement in performance or knowledge gaps.