Patient Safety and Quality Improvement: Moving To Where CLER Wants Residencies To Be

Matt Symkowick, MD, Assc.Program Director
Bruna Zanolini, MD, Chief Resident
Kaiser Napa-Solano Family Medicine Residency

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Objectives

1. Become familiar with the Institute for Healthcare Improvement (IHI) Open School and the VA National Center for Patient Safety and describe how to integrate their trainings into a residency curriculum
2. Design and implement a Patient Safety Activity to introduce *and name* a Culture of Safety in your institution
3. Understand how to use M and M conference to teach Quality Improvement and solidify resident and faculty QI skills.

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1. Patient Safety
2. Healthcare Quality and Improvement
3. Transitions in Care
4. Supervision
5. Duty Hours, Fatigue Management and Mitigation
6. Professionalism

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Overview of today's session

1. **Patient Safety and QI curriculum overview**
2. Introduction to Patient Safety Activities
3. M and M PS &QI Conference
4. "Deeper Dive"- come away with at least one tangible action item for your program

Curriculum Overview

R1	R2	R3
Patient Safety: 1. Intro to PS Didactics 2. IHI Open School 'PS 101' 3. Patient Safety Simulation	Patient Safety and Quality Improvement: 1. July Seminars 2. IHI Open School 'QI 101' 3. QI Project Design 4. MM PS&QI Leader	Patient Safety and Quality Improvement: 1. QI Project 2. MM PS&QI Leader 3. QI Elective

M and M: Patient Safety and Quality Improvement Conference

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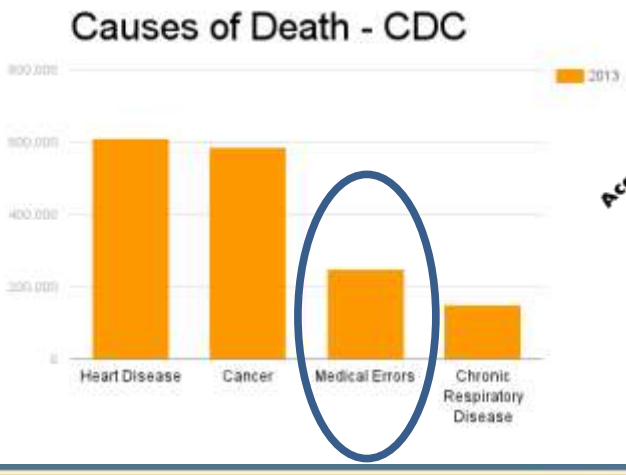
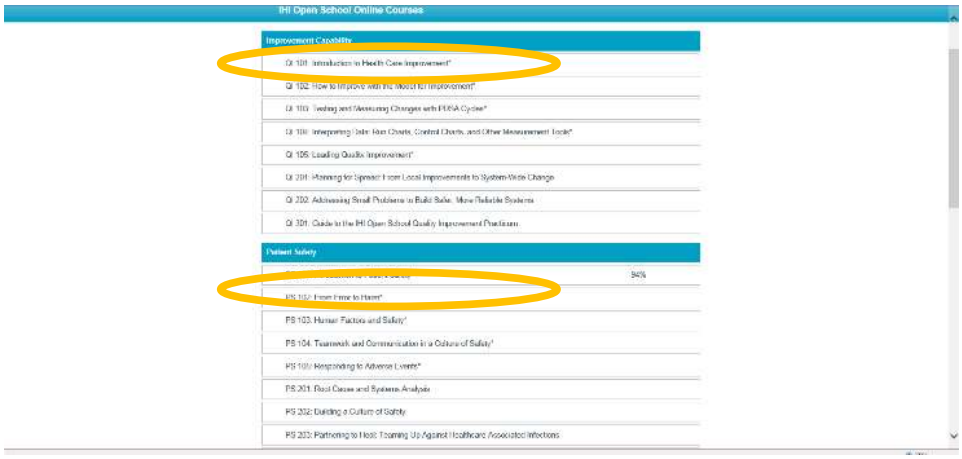
Introduction to Patient Safety Didactics



IHI Open School- Introduction to Patient Safety



Patient Safety Simulation

1. Physical Space- hospital/ training room

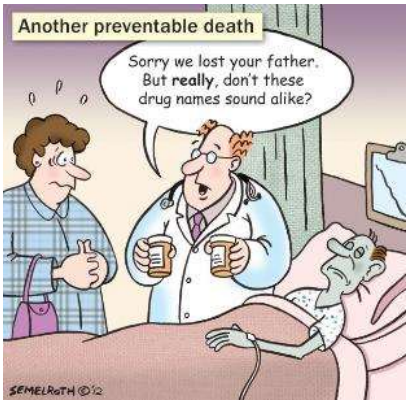
2. Partners-
   - Nursing Education
   - Hospital Administrator
   - Patient Liaison

3. Scenario

Patient Safety Simulation-

July 2017 Highlights

- 'Fall Precautions' sign posted, but no bracelet or skid socks
- Puddle on floor
- Foley in place with bag lying on the floor
- Oxygen connected to air
- IV tangled on bed rails
- Medicine from another patient with a similar name in the room
- NPO yet food next to bed
- Hand sanitizer not working



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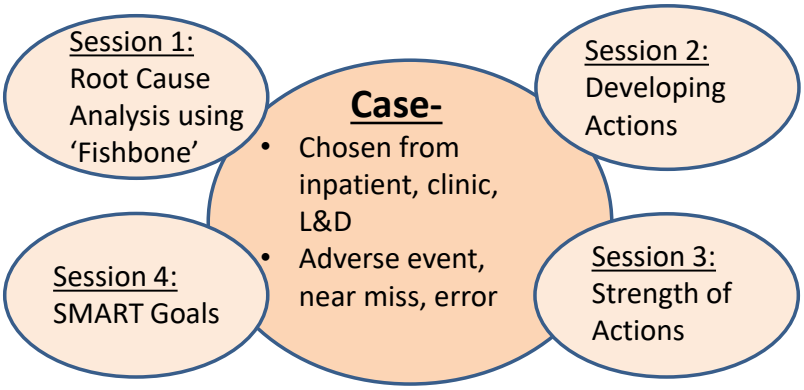
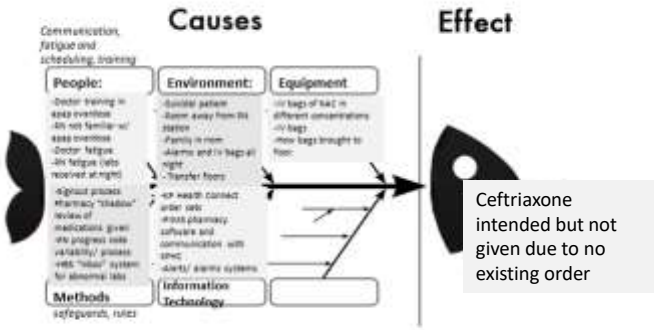
M and M: Patient Safety and Quality Improvement Conferences



Session 1: Root Cause Analysis (RCA)



Session 2: Developing Actions

- System fixes to make patient care safer
- Enhance, enforce, redesign or homogenize existing rules, safeguards, communication systems, schedules

Actions include:

- Who will do it
- What will be done
- How it will be done
- Why it will be done
- How it will be done

Session 2: Developing Actions

Sample Actions

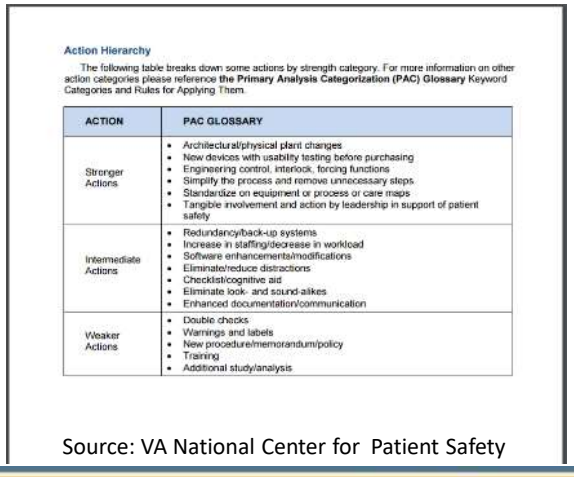
1) RN leadership and HBS leadership will *develop (standardize) a "dot phrase"* for all RN shift change notes that includes essential diagnoses and treatments and verification of "checks" *and require it to be used* to *help ensure that essential therapies are given when intended* by *forming a work group of essential stakeholders to implement the plan* within *6 months of the agreement date.*

2) The chief residents will *write a written report of what occurred in this case to the IT leadership including a draft proposal of a new, enhanced, order set by e-mail* so that *future lapses in NAC administration are reduced* by the end of October.

3) *RN leadership and HBS* will *audit clinical information placed in the HBS inbox for appropriateness by forming a working group* (standardize and redesign) that meets quarterly and reviews eRRF (adverse events reports) and other reported incidents *to reduce the number of adverse events* resulting from delays in HBS awareness of abnormal lab values *by the end of 2017.*

4) The FM HBS R2 and R3 will enhance sign out to include notation of medication and orders reconciliation including whether it has already been done or needs to be done *by working with residents during resident- chief meeting time to develop a standard process* to reduce the number of errors in essential therapies provided FM HBS patients *by January 1,2018.*

Session 3: Strength of Actions



Action Hierarchy

The following table breaks down some actions by strength category. For more information on other action categories please reference **the Primary Analysis Categorization (PAC) Glossary** Keyword Categories and Rules for Applying Them.

ACTION	PAC GLOSSARY
Stronger Actions	• Architectural/physical plant changes • New devices with usability testing before purchasing • Engineering control, interlock, forcing functions • Simplify the process and remove unnecessary steps • Standardize on equipment or process or care maps • Tangible involvement and action by leadership in support of patient safety
Intermediate Actions	• Redundancy/back-up systems • Increase in staffing/decrease in workload • Software enhancements/modifications • Eliminate/reduce distractions • Checklist/cognitive aid • Eliminate look- and sound-alikes • Enhanced documentation/communication
Weaker Actions	• Double checks • Warnings and labels • New procedure/memorandum/policy • Training • Additional study/analysis

Source: VA National Center for Patient Safety

Session 4: SMART goals

Specific

Reduce the number of delays of 1 hour or more of essential therapies (ie. antibiotics, diuretics, IV hydration, anticoagulation, corticosteroids) that are documented in note plans but not administered due to a lack of a valid order by 25% over the next 6 months to improve the efficiency of treatment and reduce length of stay.

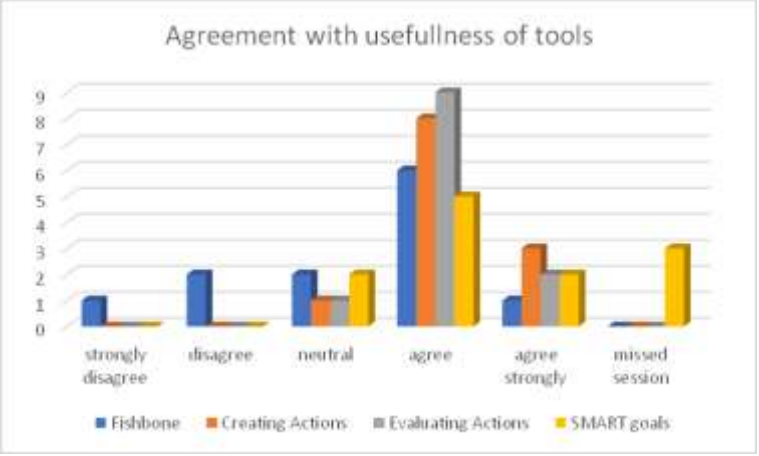
Time-bound

Relevant

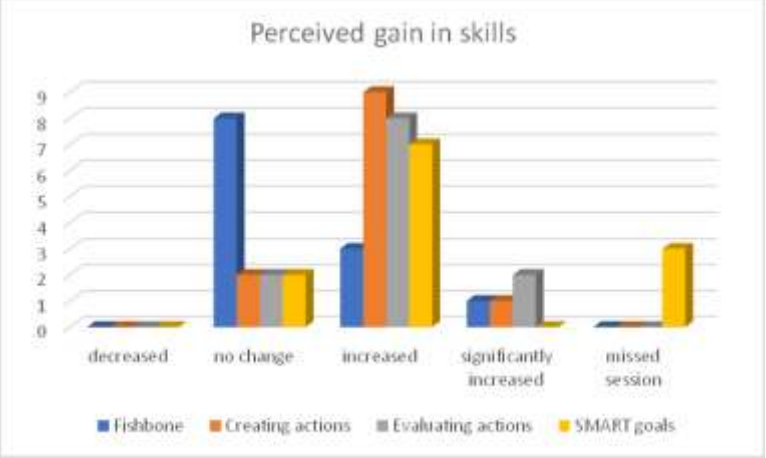
Attainable

Measurable

M and M Curriculum Assessment



M and M Curriculum Assessment



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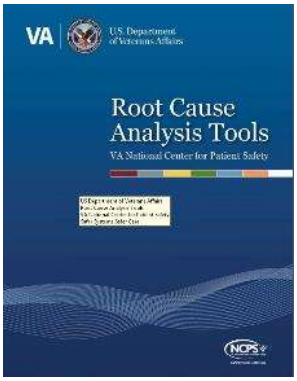
“Deeper Dive”

come away with at least one tangible action for your program

- Explore IHI Open School and VA Root Cause Analysis Tools and how to integrate into your curriculum
- Develop a patient safety activity
- Plan a M and M based on Patient Safety and Quality Improvement

IHI and VA materials for curriculum integration

http://www.ihi.org/education/IHIOpenSchool/Courses/Documents/IHI%20OS%20Faculty%20Curriculum%20Integration%20Guide%20Februrary%202017%20Final.pdf



https://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf

“Deeper Dive” - Group Session

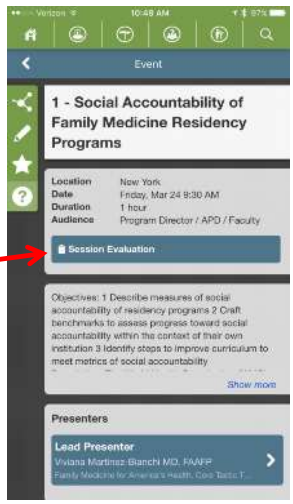
- Divide into groups of 3 people
- Discuss current PS & QI activities in your programs
- Envision ideal PS & QI activities for your programs
- Develop a SMART goal

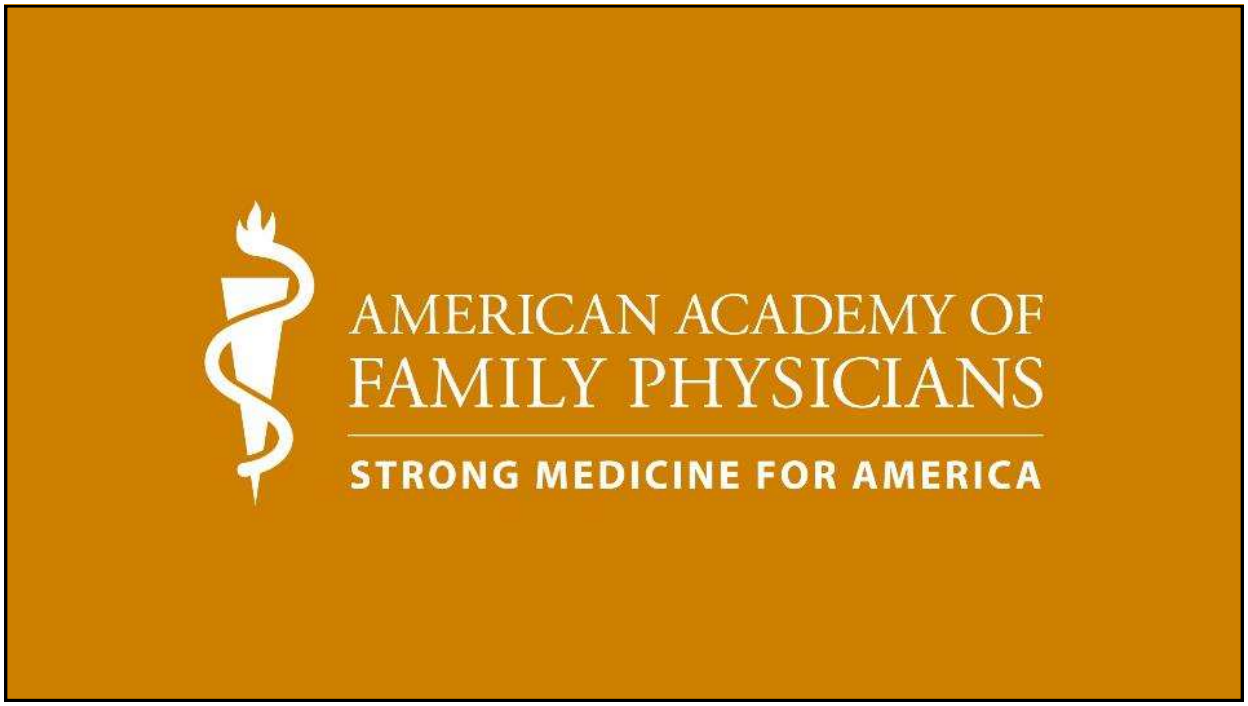
Please

complete the

session evaluation.

Thank you.

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