What Happens to My Event Report?
A Quality Improvement (QI) Education Initiative

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Background

• The Accreditation Council of Graduate Medical Education (ACGME) requires resident participation in QI activities

• We teach QI tools using interactive case-based morning reports to analyze actual event reports

• Studies show physicians rarely report adverse events, citing “lack of knowledge around event reporting” as a major cause

• Inter-professional teams are vital to QI science
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Objectives of QI Morning Report

• Describe next steps after submission of patient safety event reports

• Use QI tools to analyze these events

• Recognize unique expertise of inter-professional teams

• Identify actionable next steps
PDSA cycle and Model for Improvement—1991, 1994

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective.
- Questions and predictions.
- Plan to carry out the cycle (who, what, where, when).

**Do**
- Carry out the plan.
- Document problems and unexpected observations.
- Begin data analysis.

**Study**
- Complete the data analysis.
- Compare data to predictions.
- Summarize what was learned.

**Model for Improvement**
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?
Conceptual view of a driver diagram

Outcome

Primary drivers
- Primary driver 1
- Primary driver 2
- Primary driver 3

Secondary drivers
- Secondary driver 1
- Secondary driver 2
- Secondary driver 3
- Secondary driver 4
- Secondary driver 5

Specific change ideas
- Ideas: 1, 2, 3, 4, 5, 6, 7, 8, 9, ..., N

Change concepts
- Concept 1
- Concept 2
- Concept 3
- Concept 4
- Concept 5
- Concept 6
Results

• Conference evaluation scores have been high (average 4.0 ranking on 1 – 5 scale)

• Multiple residents early in their training have shown interest in pursuing specific QI projects
Results

• Key actionable items include:

  - Changing Epic orders to include hyaluronidase administration when vesicants are ordered
  - Introducing residents to the SBAR method of sign out
  - Recommending pulmonary toilette be included in order reconciliation across phases of care
Conclusions

Teaching QI science

Interactive morning report teaching QI tools
Conclusions

What happens to my event report?

Walk through process analysis using QI tools
Conclusions

Forming Inter-disciplinary teams

Encourage active participation in improving system processes