IMPLEMENTATION OF A RESIDENT-LED QUALITY AND SAFETY CONFERENCE

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Background
Residents are often the front line caretakers for patients and are directly involved in providing safe and quality care, yet they are not always included in review or implementation of measures to improve quality and safety within their institutions. The ACGME CLER program has called for resident engagement in an institution’s Patient Safety and Quality Improvement programs as two of the six components which affect patient outcomes and determine residency accreditation. Quality and safety initiatives have been found to be most effective when interdisciplinary teams are involved, faculty are engaged, and residents are encouraged to take a leadership role in execution of the initiative.

Aims
• Increase resident recognition and reporting of safety concerns affecting pediatric inpatients
• Engage residents in implementation of improvement measures

Study Design
• Monthly Pediatric Quality and Safety Conference introduced in July 2014.
• Goal: review, analyze safety events identified for Pediatric inpatients
• All residents on inpatient teams asked to:
  - Identify at least one safety event in which they were involved or that they witnessed
  - Enter the event into the system-wide online “Safety Net” program
  - Present event to peers, medical students, attending during the Quality and Safety conference held at the end of each rotation
• One senior resident is designated to focus on one event in detail, and describe at least one potential intervention that has been or could be implemented to improve safety
• Reported events tabulated by Chief Residents and Program Director and stratified into error types, based on Institute of Medicine stratification.

Preliminary Results
• From July 2014 to July 2015, 108 events were reported in the quality and safety conference with the inference that at least one error was submitted into the online safety net program per resident per rotation.
• This represents 100% participation by residents assigned to the inpatient service.
• The event types identified most commonly include communication errors (46), avoidable delay in treatment or in responding to an abnormal test (20), and other system failure (12) using IOM types of medical errors.

• From 7/1/14-6/30/15 on 2-West and PICU, 56 safety events were reported by residents into the safety net
• Resident QI Conference
  -12 Conferences from July - June
  -108 safety events presented and discussed
• Gap between those reported at conference and those reported into Safety Intelligence 108 vs 56

Total Errors Reported
2013/14: 0
2014/15: 56

Questions
• What are some ways to evaluate our research question: “Does a resident-driven conference increase resident engagement and leadership in safety events?”
• Is there a way to retrospectively look back at this past 1.5 years of conferences and interpret impact with out a pre-survey?
• Would this project be more successful if looked at from an educational quality improvement standpoint?
• How and where could this type of research be published?

Future Plans/Timeline
Next steps:
• Determine if implementation of this conference has changed the safety culture in our pediatric program
• Identify potential solutions to reported errors
• Assess efficacy of implemented solutions
• Expand conference to other clinical service areas in Pediatrics, and other GME programs at our institution

Research and Scholarship Task Force Works-In-Progress Symposium/Mini Poster