ABSTRACT: Griswold ELAM Institutional Action Project one-page FINAL – March 2018

Project Title: Make some **NOISE** (**N**ear Miss **O**pportunities to **I**mprove our **S**afety **E**nvironment): Promoting awareness and engagement of patient safety close calls.

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Category: Clinical

Background, Significance:

Medical error is a prevalent problem the US. A recent controversial article claimed that medical error is the third most common cause of death in the US. The ACGME has implemented new requirements to incorporate patient safety practices for all GME.

Impending ACGME changes mandate that all members of the healthcare team are aware of sentinel event/ incident report/ near miss (NM) reporting systems and that summative incident report and NM data is routinely shared with housestaff. NM experiences (close calls) represent the tip of the iceberg in learning opportunities for patient safety as they occur 300 times more often that harm events.

The purpose of this project is to institutionalize the new ACGME requirements by creating collaboration within the clinical and GME programs around patient safety goals.

Objectives:

1. Demonstrate a 10% increase in the reporting of NM events within the institution (by July 1, 2019)
    a. Obtain baseline and (18 month) follow up RCA, near miss event reporting data.
2. Identify a Patient Safety and Quality Leader (faculty champion) in each clinical department and provide additional faculty development (July 1, 2018)
    a. Establish a GMEC Patient Safety subcommittee.
    b. Initiate and sustain a "**Campaign for Culture Change"** via:
        i. Meet with all key stakeholders
        ii. Strategic Plan Development by July 1, 2018

Methods/Approach/Evaluation Strategy:

What outcome will you measure to demonstrate you have met the objective?	**What tool will you use to measure the outcome?**	**When will you measure the outcome?**
Pre and Post RCA & NM and incident report data	The institution currently tracks all RCA, NM and incident report data.	4.18 and 4.19
% of clinical departments that have changed M&M Conference to QI and Patient Safety Conference.	A survey distributed to clinical chairs in the institution.	4.18 and 4.19
% of stakeholders completing National Patient Safety Foundation – Patient Safety Curriculum	A survey distributed to all task force members.	7.18 and post 7.19

Outcomes/Results:

The patient safety leadership reported 2016 baseline data of:

- 2,277 patient safety event reports - 36 (1.6%) submitted anonymously.
- 22 root cause analyses (RCAs) were conducted.
    - 45 of 575 (8%) of residents and fellows participated in one or more of the investigations.

Discussion/Conclusion with Statement of Impact/Potential Impact:

Near Miss and RCA events are fertile learning grounds to prevent downstream recurrence of patient safety issues. Only 8% of residents participated in baseline RCAs. None participated in a NM investigation. It is no longer acceptable for healthcare organizations to imply "we will not investigate and take corrective action until a serious injury or major damage occurs." Future changes by the ACGME mandate that residents meaningfully contribute within patient safety culture of healthcare environments.