POLICY ON PATIENT SAFETY

I. Rationale

In accordance to the ACGME Clinical Learning Environment Review (CLER), the West Virginia University Office of Graduate Medical Education must ensure that residents are educated and engaged in patient safety activities or programs.

II. Scope

This policy applies to all graduate medical education programs sponsored by the West Virginia University School of Medicine.

III. Policy

A. Programs should encourage and support residents to work in interprofessional teams to enhance patient safety and improve patient care quality. *Common Program Requirements VI.A.5.f).(5).*

B. Programs should encourage and support residents to participate in identifying system errors and implementing potential systems solutions. This can be achieved through the following activities or program:

1. Reporting of adverse events and near misses/close calls to improve system of care.
2. Participation in in interprofessional, interdisciplinary, systems-based improvement efforts such as patient safety event reviews and analyses (i.e. department level Morbidity and Mortality Conferences, institution or department level Root Cause Analysis of adverse events)

Adapted from: Common Program Requirements VI.A.5.f).(6).

C. Program directors should provide feedback to residents when they are involved in patient safety events.

D. Programs must develop policies to ensure all residents and fellows are instructed in patient safety.

1) Programs must incorporate patient safety instruction into its curriculum.
2) All residents and fellows must complete the WVU Office of Graduate Medical Education assigned self-directed modules from the Institute for Healthcare Improvement (IHI) Open School.
3) Any alternate format of instruction must be submitted for review by the WVU Office of Graduate Medical Education Patient Safety Subcommittee.
4) It is recommended that residents and fellows receive additional instruction in the form of small or large group discussions or workshops.

E. Programs must develop competency-based goals and objectives that pertain to instruction in patient safety and participation of resident or fellows in patient safety activities.

Adapted from: Program Director Guide to the Common Program Requirements, 2012. Each assignment in which the resident is expected to participate must have a set of competency-based goals and objectives. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation.

F. Programs, through the Program Evaluation Committee (PEC), must evaluate instruction in patient safety and participation of resident or fellows in patient safety activities at least annually.

IV. Evaluation

A. Monitor resident and fellow completion of mandatory IHI Learning Modules.

B. Monitor resident and fellow scores and passing and failing rate in the IHI Learning Modules post-test.

Approved by GMEC – 11/18/2016

APPENDIX A: Patient Safety Curriculum

Periods	Step 1: Basic	Step 2: Advanced
1. ***Errors happen every day… some results into harm*** Activity: • Self-paced Learning • ***Basic:*** Observe in a Root Cause Analysis (RCA) • ***Advance:*** Participate in a Root Cause Analysis (RCA)	PS 101: Introduction to Patient Safety • Lesson 1: Understanding Medical Error and Patient Safety *(30 minutes)* • Lesson 2: Responding to Errors and Harm *(30 minutes)* • Lesson 3: A Call to Action – What YOU Can Do *(30 minutes)* PS 101: From Error to Harm • Lesson 1: The Swiss Cheese Model *(20 minutes)* • Lesson 2: Understanding Unsafe Acts *(25 minutes)* • Lesson 3: A Closer Look at Harm *(15 minutes)*	PS 202: Building a Culture of Safety • Lesson 1: Leading Health Systems Through Adverse Events *(15 minutes)* • Lesson 2: What Does a Culture of Safety Look Like? *(30 minutes)* PS 201: Root Cause and Systems Analysis • Lesson 1: Root Cause Analysis Helps Us Learn from Errors *(30 minutes)* • Lesson 2: How a Root Cause Analysis Works *(30 minutes)* • Lesson 3: How Root Cause Analysis Can Help Improve Health Care *(30 minutes)*
2. ***"By nature, we are hard-wired in such a way that errors are inevitable… to overcome this we must work as a team."*** Activity: • Self-paced Learning • ***Advanced:*** Participate in a simulated event in disclosure	PS 103: Human Factors and Safety • Lesson 1: Understanding the Science of Human Factors *(20 minutes)* • Lesson 2: Changes Based on Human Factors Design Principles *(20 minutes)* PS 104: Teamwork and Communication • Lesson 1: Why are Teamwork and Communication important? *(25 minutes)* • Lesson 2: How Can You Contribute to a Culture of Safety? *(25 minutes)*	PS 105: Responding to Adverse Events • Lesson 1: Responding to an Adverse Event: A Step-by-Step Approach *(30 minutes)* • Lesson 2: When and How to Apologize to Patients *(20 minutes)* • Lesson 3: The Impact of Adverse Events on Caregivers: The Second Victim *(25 minutes)*