UTRGV School of Medicine	**Category:** Graduate Medical Education **Effective Date:** July 1, 2017 **Last Review/Revision Date:** November 14, 2024 Page 1 of 3
Title: Patient Safety and Quality Improvement GME Policy	
Reference: ACGME Institutional and Common Program Requirements; ACGME Glossary of Terms	

I. Purpose

The Accreditation Council for Graduate Medical Education (ACGME) requires that every Sponsoring Institution (SI) oversee and document all its programs, faculty members and residents' engagement in patient safety and quality improvement activities as part of achieving the systems-based practice competency for residents. This not only includes working in interprofessional teams to enhance patient safety and patient quality but also participating in identifying system errors and implementing potential system solutions.

Thus, in recognition of the importance of quality improvement and patient safety (QIPS) as vital elements of learning and working environment, this policy aims to ensure that all residents and the programs have appropriate measures and structures to enable residents to engage in quality improvement and patient safety activities.

II. Background

Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

All physicians, including residents, share the responsibility for enhancing the quality of patient care and promoting patient safety. Graduate medical education (GME) must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. Residents must demonstrate the ability to analyze the care they provide in an interprofessional setting, understand their roles within health care teams, and play an active role in system improvement processes. Thus, upon graduation, they will be able to apply these skills to critique their future unsupervised practice and effect quality improvement measures.

III. Definitions

Culture of safety: A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective program has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety to identify areas for improvement. We must have a blame-free environment and culture where all individuals are able to report errors or near misses without fear of reprimand or punishment.

Safety event: An adverse event, near miss, or other event resulting from unsafe conditions in the clinical care setting. May also be referred to as a patient safety event; previously referred to as adverse event.

Cultural humility: The practice of ongoing self-reflection on how one's background and the background of others impact teaching, learning, research, creative activity, engagement, leadership, etc.

IV. Patient Safety and Quality Improvement Policy

A. Duty to Report-

i. Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (CPR 6.2.a.)
ii. The duty to report is covered in GME orientation and hospital orientation and extends to all healthcare professionals including residents, fellows, faculty members and other clinic staff.
iii. Safety events can include medication errors, adverse medication reactions, falls, decubitus ulcers, deep vein thrombosis, unexpected changes in levels of care, transitions of care fallouts, hospital acquired infections, antibiotic stewardship and others.

B. Access to Report-

i. The SI ensures the residents/fellows have access to systems for reporting errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal. (IR 3.2.a.)
ii. This is documented in the Annual Program Evaluation (APE) form in New Innovations, reviewed by the DIO and the SI through the APE Peer review process.

C. Access to Data-

i. The SI provides summary information of our institution's patient safety reports and data related systems of care, health care disparities and patient outcomes at least annually, as documented in GMEC and distributed to residents and faculty. (CPR 6.2.a. and IR 3.2.b.)
ii. In addition, the SI report, programs must collect at least two site and specialty specific quality measures and distribute to their residents and faculty at least annually. Completion is tracked in the APE.

D. Experiential Learning-

i. The SI offers Patient Safety and Quality Improvement development opportunities to faculty and residents on our development portal, Grand Rounds, and orientation. The SI encourages residents to use the Institute for Healthcare Improvement courses or any other tools and resources they might find helpful.
ii. The SI ensures that residents/fellows participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analysis, as well as formulation and implementation of actions. (IR 3.2.a.1. and CPR 6.3.)
iii. The SI provides interprofessional mock root cause analyses for all residents during orientation as well as collects data and ensures program-level opportunities through the APE and APE peer review process. This mock root cause analysis includes action plan development.
iv. In addition, the SI training, programs must provide real and/or simulated interprofessional clinical patient safety and quality improvements, such as root cause analysis, Morbidity & Mortality conference which includes an action plan, Plan-Do-Study-Act, or Failure Mode and Effect Analysis (FMEA) team. Completion including percentage of residents involved and list of projects is tracked in the APE.

v. Programs must demonstrate, typically through milestones and evaluations, that residents in their training program can:
   - Identify strengths, deficiencies, and limits in their own or in others' knowledge and expertise including the practice of cultural humility
   - Establish learning and improvement goals for their own identified deficiencies and identify and perform appropriate learning activities
   - Systematically analyze their own practice and that of other healthcare providers using quality improvement methods, and implement changes with the goal of practice improvement
   - Be able to incorporate formative evaluation feedback from quality and patient safety activities into daily practice
   - Locate, appraise, and assimilate evidence from scientific studies related to patients' health problems