

Utilizing the Safety Huddle to Empower Residents as Safety Stewards (USHERSS)

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Setting and Problem

Nearly every person in the United States will experience a diagnostic error in their lifetime.¹ Reporting events that do or have the potential to cause patient harm is an important aspect of improving patient safety and enhancing health care quality and is a crucial step toward development of high-reliability health care organizations. Residents are frontline workers who must be involved in patient safety. By the end of their training program, residents must know their responsibilities regarding what patient safety events to report, how to report these events, and how to participate as team members in interprofessional patient safety activities. The Accreditation Council for Graduate Medical Education (ACGME) Clinical Learning Environment Review (CLER) National Report of Findings 2021 noted that generally trainees lacked understanding and awareness of the range of reportable events and had little awareness for the importance of reporting these events.² At our institution, physicians were responsible for reporting less than 1% of submitted patient safety reports. With the COVID-19 pandemic, our institution also had a 35% decrease in event reports filed by physicians from calendar year 2020 to 2021. Furthermore, many of our residents did not know what events to report or how to report the events despite education delivered at institutional onboarding and through program didactics.

Intervention

In academic year 2022-2023, we developed a quality improvement project entitled Utilizing the Safety Huddle to Empower Residents as Safety Stewards (USHERSS). We engaged programs to identify trainee patient safety champions to facilitate safety huddles. The safety huddle would allow the programs to (1) create situational awareness around patient safety events; (2) increase event reporting; and (3) promote standard patient safety work. Each champion was

educated on how to facilitate a standard patient safety huddle. The standard huddle consisted of 3 phases: (1) Items of quality: “What items of quality should we share?”; (2) Look back: “Since the last huddle, what safety concerns have you witnessed or experienced?” “Have the concerns been reported?” “What action items should be accomplished for the safety concern?”; and (3) Look forward: “Before our next safety huddle, what safety concerns should we anticipate or address?” “Have we escalated the concerns discussed to the appropriate leader?” The USHERSS program safety huddle guide is provided in the online supplementary data. Each participating program had a dashboard that tracked event reports from stakeholders in their program. At the institutional level, we tracked number of safety huddles completed, duration of safety huddles, number of event reports, and items that required escalation. In addition to the safety huddles, we created program incentives (Great Catch Program, a graduate medical education [GME] incentive for educational funds) and integration with the institutional GME Patient Safety Council.

Outcomes to Date

In this 12-month initiative, the USHERSS program was able to increase recognition and reporting of safety events by trainee and faculty physicians to an average of 30 events filed per month from a baseline average of 5 event reports per month. Feedback from trainees demonstrates that programs now have a “safe space” for reporting with “more openness” to discuss events, and that trainees are more aware of what and how to report. The 13 enrolled GME programs held 87 safety huddles with a median duration of 15 minutes (5 to 60 minutes). Huddles were primarily resident led and occurred once a month in a required resident forum. The Great Catch Program has recognized 31 physicians.

References

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Editor's Note: The online supplementary data contains the USHERSS program safety huddle guide.

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