OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER

Increasing Prevalence of Safety Event Reporting by Residents At Our Lady of the Lake Hospital

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Introduction

- ACGME established the CLER Program to provide recommendations for integration of safety event reporting into graduate medical education
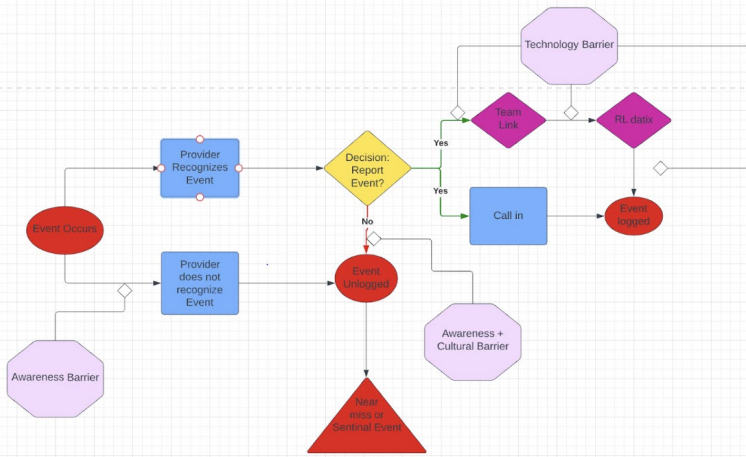
- Barriers to safety event reporting were identified such as lack of awareness of safety events, no closed loop communication on reported events outcomes, and being unfamiliar with the reporting process

Background

2.8% Small percentage of all reported safety events in 2021 were attributed to "learners" which consisted of resident, students and non-HMS physicians

Gap: Residents likely comprise a small fraction of the 2.8% identified, highlighting an opportunity for improvement in resident reporting
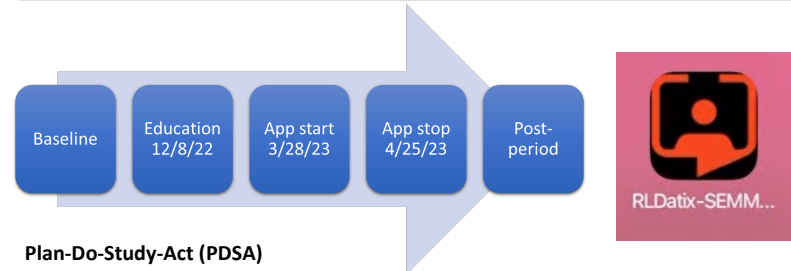
- RCA identified 3 barriers: awareness, culture, and technology

Study Purpose

- To increase the amount of safety events reported by residents through increasing resident awareness of the safety event reporting system and streamlining the process of submitting a safety report
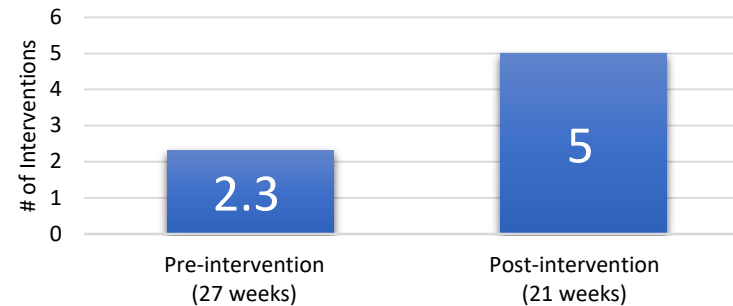
Methods

Plan-Do-Study-Act (PDSA)

- Educational lectures comprised the first intervention to address awareness barriers
- Creation and dissemination of a RLDatix smartphone app comprised the second intervention to address technology barriers
  - App access only available to residents
  - Evaluated safety events entered before and after app availability
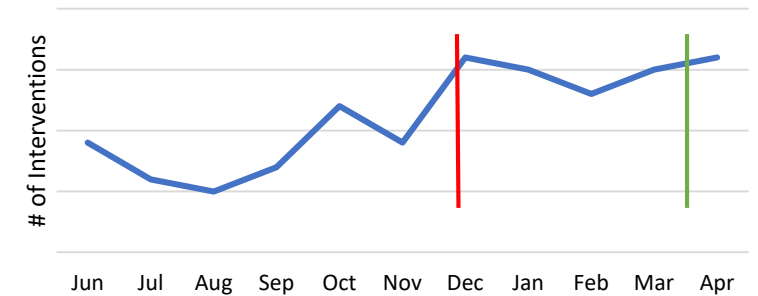
Results

Events Entered Per Week

Safety Events Reported via RLDatix App, no.	
Total events reported	9
Events reported during app intervention period*	5

*3/28/2023 to 4/25/2023

Results

Interventions Per Month

Red line denotes pre- v. post-intervention period starting 12/8/2022
Green line denotes integration of smartphone app

Discussion and Conclusions

- GME reporting of safety events nearly doubled following education and technology interventions

- Creation and dissemination of the RLDatix smartphone app did not demonstrate meaningful improvement in event reporting

- Some limitations of this study include: short study window, limited lead time of app implementation, lack of a process for workflow integration

- Future studies addressing workflow integration and senior staff familiarity with the reporting process are needed to further evaluate these findings

References

- National Report of Findings 2016. Issue Brief No. 2. Patient Safety. Clinical Learning Environment Review.
- Nasca TJ, Weiss KB, Bagian JP. Improving clinical learning environments for tomorrow's physicians. N Engl J Med. 2014;370:991-3.
- Attitudes of Physicians in Training Regarding Reporting of Patient Safety Events. Journal of Clinical Outcomes Management. 2015 November; 22 (11).