Icahn School of Medicine at Mount Sinai

GME QUALITY IMPROVEMENT AND PATIENT SAFETY NEWSLETTER

MESSAGE FROM THE GME ASSOCIATE DEANS FOR QI & PS

Dear MSHS Residents, Fellows and Faculty,

For our first issue of the 2022-2023 academic year, we would like to welcome all incoming residents and fellows to the Mount Sinai Hospital System! House staff participation in Quality Improvement and Patient Safety initiatives are vital for our hospitals' efforts to bring the best care to patients, and so we hope you will find this bimonthly newsletter to be useful in your professional journeys.

Whether you are new or established in the realm of hospital quality improvement and patient safety, we thought it would be helpful to share an FAQ on Serious Adverse Events and how they are addressed in the Mount Sinai Hospital System (see page 2). We also want to take an opportunity to plug the Institute for Healthcare Improvement (IHI) Open School which provides online courses in quality improvement and patient safety. This resource is free for all trainees courtesy of the GME office. We highly encourage you to take advantage of these courses. Please read for more details on how to register and earn the Open School Certificate.

For this issue's QI Spotlight, we are delighted to feature the MSH Pulmonary, Critical Care & Sleep Medicine department and their completion of the Level 100 Basic Continuous Improvement course. As part of the course, faculty preceptors Dr. Kathryn Dubowski and Dr. Jing Wang led their team of fellows, Dr. Adiac Espinosa Hernandez (PGY-6), Dr. Shyla Saini (PGY-5), and Dr. Kateryna Yevdokimova (PGY-6), to complete a waste walk and apply 6S Lean process improvement techniques to their bronchoscopy suite.

Congratulations to the 13th annual Graduate Medical Education Consortium Research Day winners! See page 5 for the list of winners and a link to all submissions.

As of July 5, 2022, to comply with the "21st Century Cures Act" the MSHS started to significantly expand the sharing of clinical data with patients via MyMountSinai (MyChart). See page 6 for more details including an FAQ.

Additionally, you can find links to QI/PS related publications in our "In the Literature" section, courtesy of the Agency for Healthcare Research and Quality Weekly Digest.

Lastly, we provide the latest 12-month resident and fellow SafetyNet reporting data. For those new to this newsletter, we highly encourage you visit this section of the newsletter to familiarize yourself with SafetyNet, the MSHS adverse event reporting system. Increasing patient safety reporting is a 2022 MSHS Safety Goal and we need your participation!

As always, we appreciate everyone's efforts to promote a culture of safety reporting!

Brijen Shah, MD
GME Associate Dean for QI and PS

Daniel Steinberg, MD
GME Associate Dean for QI and PS

CONTENTS

Serious Adverse Events FAQ

What is a Serious Adverse Event?
Serious Adverse Events result from flaws in medical management as opposed to an underlying disease or condition of a patient. Many adverse events are preventable, but some are not. Adverse Events range from risking harm to actually causing harm to patients and/or staff.

The Centers for Medicare & Medicaid Services defines an Adverse Event as "an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or risk thereof." The Joint Commission defines an Adverse Event as "an unexpected occurrence involving death or serious physical or psychological injury or risk thereof."

How are Serious Adverse Events addressed?
There is a four step process for addressing Serious Adverse Events:
1. Huddle
2. Debrief
3. Root Cause Analysis (RCA)
4. System Safety Solution (SSS)

What is a Huddle?
A Huddle is a team meeting immediately following an adverse event. During a Huddle, the team will decide on how to best care for the patient and others involved. Additionally, an incident report will be entered. The Mount Sinai Health System uses **SafetyNet** to log adverse events.

What is a Debrief?
A Debrief is a team meeting that occurs within 72 hours of an adverse event. These meetings are attended by the involved front-line providers and are facilitated by hospital leadership including the Chief Medical Officer. The point of the Debrief is to collaboratively discuss a timeline of the adverse event at hand, but NOT to place blame on anyone or thing in particular. Involved parties will also decide on what other information needs to be collected.

What is a Root Cause Analysis (RCA)?
A Root Cause Analysis (RCA) is a comprehensive, system-based review process for adverse events. The purpose of the RCA is to identify and critically examine the basic factors, or root causes, of an adverse event. RCA's are non-punitive and meant to be as impartial as possible. Tools such as timelines, process maps, causal trees and fishbone diagrams are used for analysis in an RCA. These meetings are facilitated by hospital leadership, including those in clinical and operational areas. Residents and fellows are highly encouraged to attend and observe RCA's.
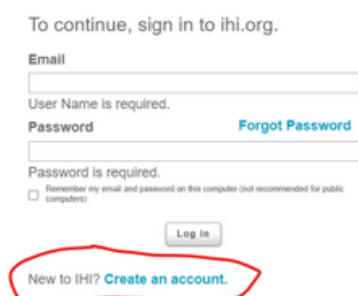
What is a System Safety Solution (SSS)?
The System Safety Solution is the last step in the Adverse Event Process. During this meeting, hospital leadership will devise logistics and other plans for implementing the necessary system-level changes needed to prevent an adverse event from happening again.

Institute for Healthcare Improvement Open School

The IHI was founded a little over thirty years ago by a group committed to improving health care delivery with the goals of reducing errors, waste, and inefficiencies while ensuring sustainability. Their Open School is grounded in practical quality improvement methods, and the GME office at Mount Sinai finds it to be a very valuable educational resource for trainees. This resource is offered to all MSHS residents/fellows at no cost. We highly encourage you to explore the open school modules. Examples include "Introduction to Patient Safety"; "Responding to Adverse Events"; and "Root Cause Analyses and Actions".

Please see below for instructions on obtaining your free account:

1. Create an account here and click "create an account"
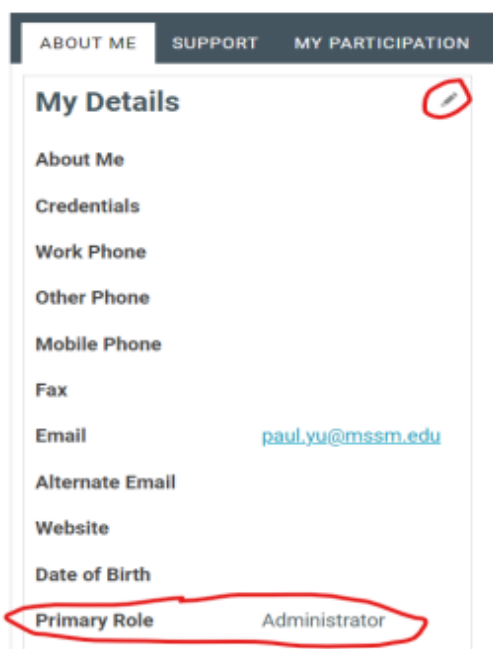
2. After entering the required information to create a new account, you will need to designate your "Primary Role." Within the About Me tab, click the pencil icon next to My Details and then adjust your Primary Role appropriately, e.g. resident.
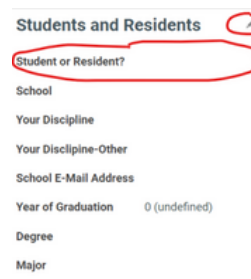
3. Additionally, if you are a student or resident, click the pencil next to Students and Residents (within the About Me tab), and mark yourself as either Resident, Student Full Time, or Student-Part Time.
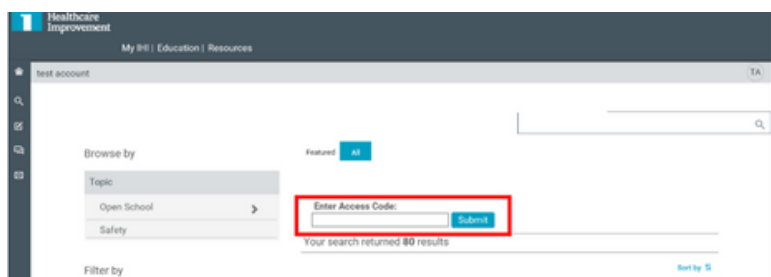

4. Once you have made your edits, you may need to log out and back in to see changes. To Access courses: Go to https://education.ihi.org. Once you are logged in, click "Browse Catalog"
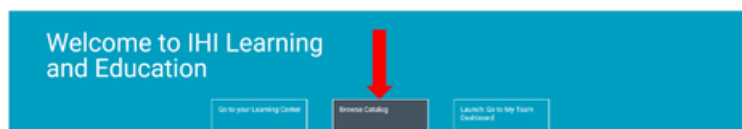
5. On the top of the page there will be a spot to enter your access code. The access code is 40249

Once you see a green bar on the top of the screen acknowledging your successful input of a valid code, all of the open school courses available to you will say "enroll." Click enroll in the courses you would like to take. Once you have enrolled in a course, it can be found in the "Learning Center." Every time you login, you can resume unfinished courses here.

The fellows of the Division of Pulmonary, Critical Care, and Sleep Medicine were eager to hone their quality improvement skills and tackle some of the inefficiencies encountered every day in the Bronchoscopy Suite. After participating in the Level 100 Basic Continuous Improvement Course, they were tasked with two assignments: Conduct a waste walk to identify inefficiencies, and conduct a 6S lean process improvement technique. In their own words, here is a summary of their experience.

Why we chose this project?
We chose to focus on the bronchoscopy room workflow since we witness inefficiencies there every day. As the volume of procedures increases, any pre and post procedural delays become magnified and can impact patient care.

What we learned from the experience?
In order to better understand what the inefficiencies were, we completed a waste walk by watching the room turnover between bronchoscopy cases. We timed every step, and watched each person involved and the role they played in the process. This involved tasks such as handling specimens at the end of the case, transporting the patient to the recovery room, cleaning the room, consenting the next patient and communicating the completion of each step in the process to the necessary staff. We learned to break down and identify areas of different types of waste. It really was an eye-opening experience.

When we completed the waste walk worksheet, we identified that the existing specimen processing system required significant time and effort for each patient. The downtime forms for specimen processing took time to find and fill out, and the area they were stored was disorganized (see figures 1 & 2). We used the 6S technique to better organize these forms. In the end, we realized an electronic option would improve specimen processing and decrease the need for paper forms. We developed an EPIC order set for specimen processing (see figure 3).
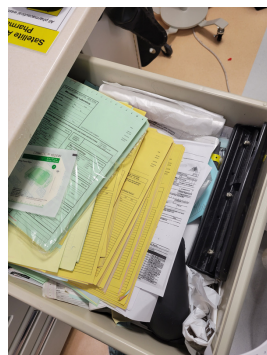
Figure 1	Figure 2	Figure 3

What are the next steps?
Our next steps are to roll out the EPIC specimen ordering system to all users and continue to troubleshoot any issues related to this. For future projects, we plan to tackle some of the other inefficiencies we observed during the waste walk exercise.

13th Annual
Graduate Medical Education
Consortium Research Day
Friday, June 3

Icahn School of Medicine at Mount Sinai
Office of Graduate Medical Education
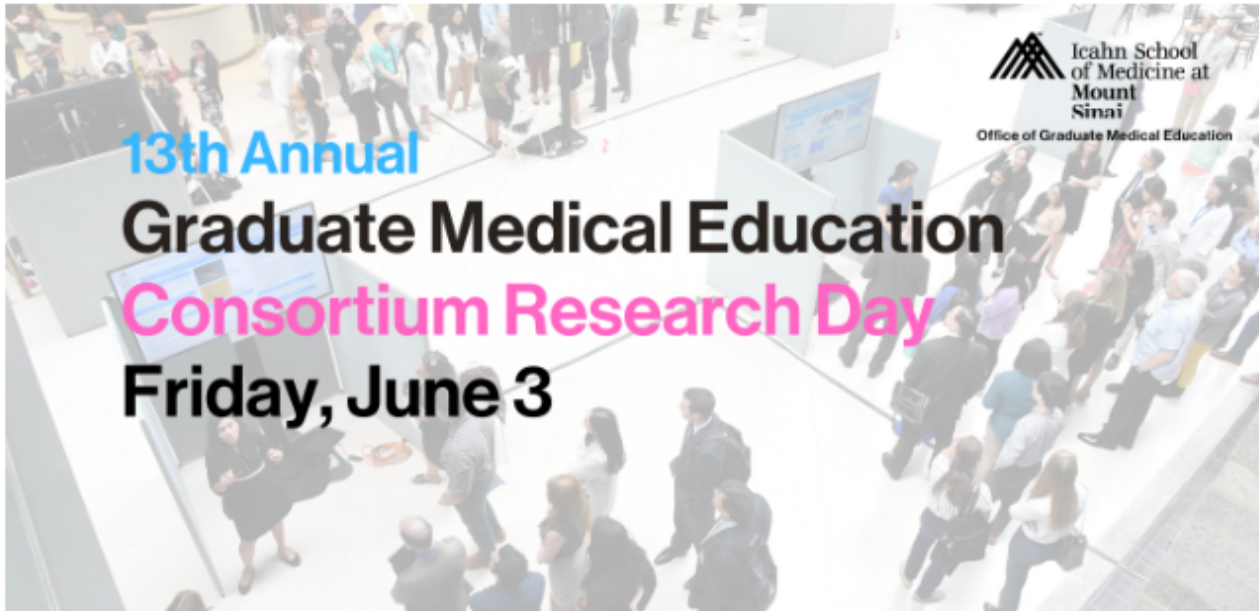
Oral Presentation Winner

Carol Shen, MD, **Pediatric Nephrology, Mount Sinai Hospital**
ABERRANT JAK/STAT SIGNALING IN NEPHROTIC SYNDROME

Poster Presentation Winners

Jose Aguilar Gallardo, MD, **Internal Medicine, Mount Sinai Morningside/West**
THE OBESITY PARADOX IN HEART FAILURE IS DEPENDENT ON ADVANCED AGE: AN INPATIENT NATIONWIDE ANALYSIS

Caroline Christianson, MD, **Pediatrics, Mount Sinai Hospital**
PEDSTALK: A PILOT COMMUNICATION SKILLS EDUCATION PROGRAM FOR PEDIATRIC RESIDENTS

Sean Lynch, MD, **Psychiatry, Mount Sinai Beth Israel**
CHANGE IN RATES OF SUBSTANCE USE IN CHILD AND ADOLESCENT PSYCHIATRY PATIENTS

Leanna Narain, PharmD, **Ambulatory Care Pharmacy, Mount Sinai Health Partners**
EVALUATION OF PHARMACIST-DRIVEN REMOTE PATIENT MONITORING (RPM) ON CLINICAL OUTCOMES AMONG PATIENTS WITH UNCONTROLLED HYPERTENSION

Parul Shanker, MD, **Psychiatry, Mount Sinai Beth Israel**
SUICIDAL IDEATION, ATTEMPTS, AND SELF-HARM AMONG CHILDREN AND ADOLESCENTS ADMITTED TO AN INPATIENT PSYCHIATRIC UNIT BEFORE AND DURING THE COVID ERA

Click Here for the Research Day Site
view posters and video presentations

System Update: Open Notes

From the offices of the MSH Chief Medical Officer and Chief Medical Information Officer

As of Tuesday, July 5, whenever lab results are entered into Epic, patients will have access to most results via the MyMountSinai patient portal. Certain result types, such as radiology, pathology, cytology, and a number of labs designated as "sensitive," will be released after a 24-hour delay. As part of this change, a button will be available in all diagnostic testing orders that allows users to set a result as "manual release only" in the event that releasing the result to the patient may be expected to cause harm to the patient or someone else.
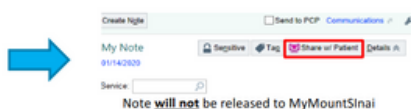
Additionally, while most notes written by providers have been available to patients via MyMountSinai, since July 5 this expanded to include all notes, including those written by nurses and ancillary staff. Behavioral health notes are also now included.

Be mindful of abbreviations or medical terminology that can be misinterpreted.

Instead of...	Consider
Provocative terms:	**Accurate, inoffensive terms :**
"complains of"	"presents with"
refuses	declines
denies	does not endorse
morbidly obese	BMI > 40 or "obese by medical criteria"
frequent flyer / bounceback	repeat visitor
Patient claims she always takes her medications, despite rising HbA1c	Patient says "I always take my medications" and is "not sure why" HbA1c is rising
Phrases that won't copy-forward well:	**Copy-friendly phrases:**
Patient was extubated yesterday	Patient was extubated Feb 5
Patient's symptoms began Friday	Patient's symptoms began two days prior to presentation

Please visit the [Mount Sinai 21st Century Cures Act Intranet Site](#) to find a comprehensive FAQ which answers many questions about the implementation of Open Notes and the updated Result Release, including whose notes will be shared and when they will be shared. Also discussed is how, and in what circumstances, to not share a note or a result. You can also find a "Guide to Good Notes" which contains high-value tips that will make your notes easier to read, more communicative of the clinical story, and less likely to cause confusion for both your clinical colleagues and your patients who will be reading them.

Prompt sharing of clinical data to patients remains a priority of the Mount Sinai Health System. If you have additional questions, please email 21stCenturyCuresAct@mountsinai.org.

In the Literature

Courtesy of the Agency for Healthcare Research and Quality Patient Safety Network

Presenting complaint: use of language that disempowers patients
Cox C, Fritz Z. BMJ. Epub 2022
As more patients are gaining access to their electronic health records, including clinician notes, the language clinicians use can shape how patients feel about their health and healthcare provider. This commentary describes how some words and phrases routinely used in provider notes, such as "deny" or "non-compliant", may inadvertently build distrust with the patient. The authors recommend medical students and providers reconsider their language to establish more trusting relationships with their patients.

Establishing psychological safety in clinical supervision: multi-professional perspectives
Lee EH, Pitts S, Pignataro S, et al. Clin Teach. Epub 2022
The inherent power imbalance between supervisors and new clinicians may inhibit new clinicians from asking questions or reporting mistakes. This lack of psychological safety can result in patient harm and restrict learning. This article provides strategies for healthcare educators and leaders to model and guide a safer organization. Three phases of the supervisor-learner relationship, along with suggested prompts, are provided.

Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018
Grimm CA. Washington DC: Office of the Inspector General; May 2022. Report no. OEI-06-18-00400
In its 2010 report, the Office of the Inspector General (OIG) found 13.5% of hospitalized Medicare patients experience harm in October 2008. This OIG report has updated the proportion of hospitalized Medicare patients who experienced harm and the resulting costs in October of 2018. Researchers found 12% of patients experienced adverse events, and an additional 13% experienced temporary harm. Reviewers determined 43% of harm events could have been prevented and resulted in significant costs to Medicare and patients.

Improving the approach to defining, classifying, reporting and monitoring adverse events in seriously ill older adults: recommendations from a multi-stakeholder convening
Baim-Lance A, Ferreira KB, Cohen HJ, et al. J Gen Intern Med. Epub 2022 May 17.
When serious adverse events such as death are reported, they are typically associated with poor patient safety. In some fields of care, however, such as palliative care, deaths are expected and are not necessarily an indicator of poor quality. This commentary describes how serious and non-serious adverse events (SAEs/AEs) are currently defined and reported, the associated challenges, and it proposes a new approach to reporting SAEs/AEs in clinical trials. A decision-tree to determine SAE/AE reporting based on the new proposed approach is presented.

Creating a learning health system for improving diagnostic safety: pragmatic insights from US health care organizations
Giardina TD, Shahid U, Mushtaq U, et al. J Gen Intern Med. Epub 2022
Achieving diagnostic safety requires multidisciplinary approaches. Based on interviews with safety leaders across the United States, this article discusses how different organizations approach diagnostic safety. Respondents discuss barriers to implementing diagnostic safety activities as well as strategies to overcome barriers, highlighting the role of patient engagement and dedicated diagnostic safety champions.

Does racism impact healthcare quality? Perspectives of Black and Hispanic/Latino patients
Findling MG, Zephyrin L, Bleich SN, et al. Healthc (Amst). 2022
Health inequities among people of color are the result of multiple systemic and clinician factors. This study shows Black and Hispanic/Latino patients who experience racism in healthcare, report worse views on the quality of their care and lower trust in their clinicians. These findings suggest that eliminating racism at the organization and clinician level may improve quality of care for patients of color.

Monitoring preventable adverse events and near misses: number and type identified differ depending on method used
Isaksson S, Schwarz A, Rusner M, et al. J Patient Saf. 2022
Organizations may employ one or more methods for identifying and examining near misses and preventable adverse events, including structured record review, web-based incident reporting systems, and daily safety briefings. Using each of the three methods, this study identified the number and types of near misses and adverse events. Results indicate that each method identifies different numbers and types of adverse events, suggesting a multi-focal approach to adverse event data collection may more effectively inform organizations.

Diagnostic challenges in primary care: identifying and avoiding cognitive bias
Rosen PD, Klenzak S, Baptista S. J Fam Pract. 2022
Cognitive biases can impede decision-making and lead to poor care. This article summarizes the common types of cognitive errors and biases and highlights how cognitive biases can contribute to diagnostic errors. The authors apply these common types of errors and biases in four case examples and discuss how to mitigate these biases during the diagnostic process.

Frailty, gaps in care coordination, and preventable adverse events
Akinyelure OP, Colvin CL, Sterling MR, et al. BMC Geriatr. 2022
Frail older adults are at increased risk of adverse events including rehospitalization and overtreatment. In this study, researchers assessed the association of care coordination and preventable adverse events in frail older adults. Compared with non-frail older adults, frail older adults reported experiencing more adverse events they believed could have been prevented with better care coordination.

SafetyNet

Below you will find SafetyNet resident and fellow reporting statistics for the 12-month period July 2021 - June 2022. The average number of total reports across campuses was 87, with March 2022 having the most reports (likely in part due to the Patient Safety Reporting Challenge week).

For those residents and fellows who recently joined us, you should have been oriented to **SafetyNet** as part of your onboarding. We hope that you will engage with the system and help us in our efforts to continue to develop a culture of patient safety reporting.

Resident & Fellow SafetyNet Reports 7/1/21 - 6/30/22

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Avg
Total	71	99	94	82	94	86	55	89	107	89	79	96	87
MSBI / NYEE	7	26	22	15	18	17	9	13	17	13	5	13	15
MSH	51	50	59	51	63	57	32	52	64	44	51	64	53
MSM	5	10	5	7	6	4	9	9	8	18	10	8	8
MSW	8	13	8	9	7	8	5	15	18	14	13	11	11
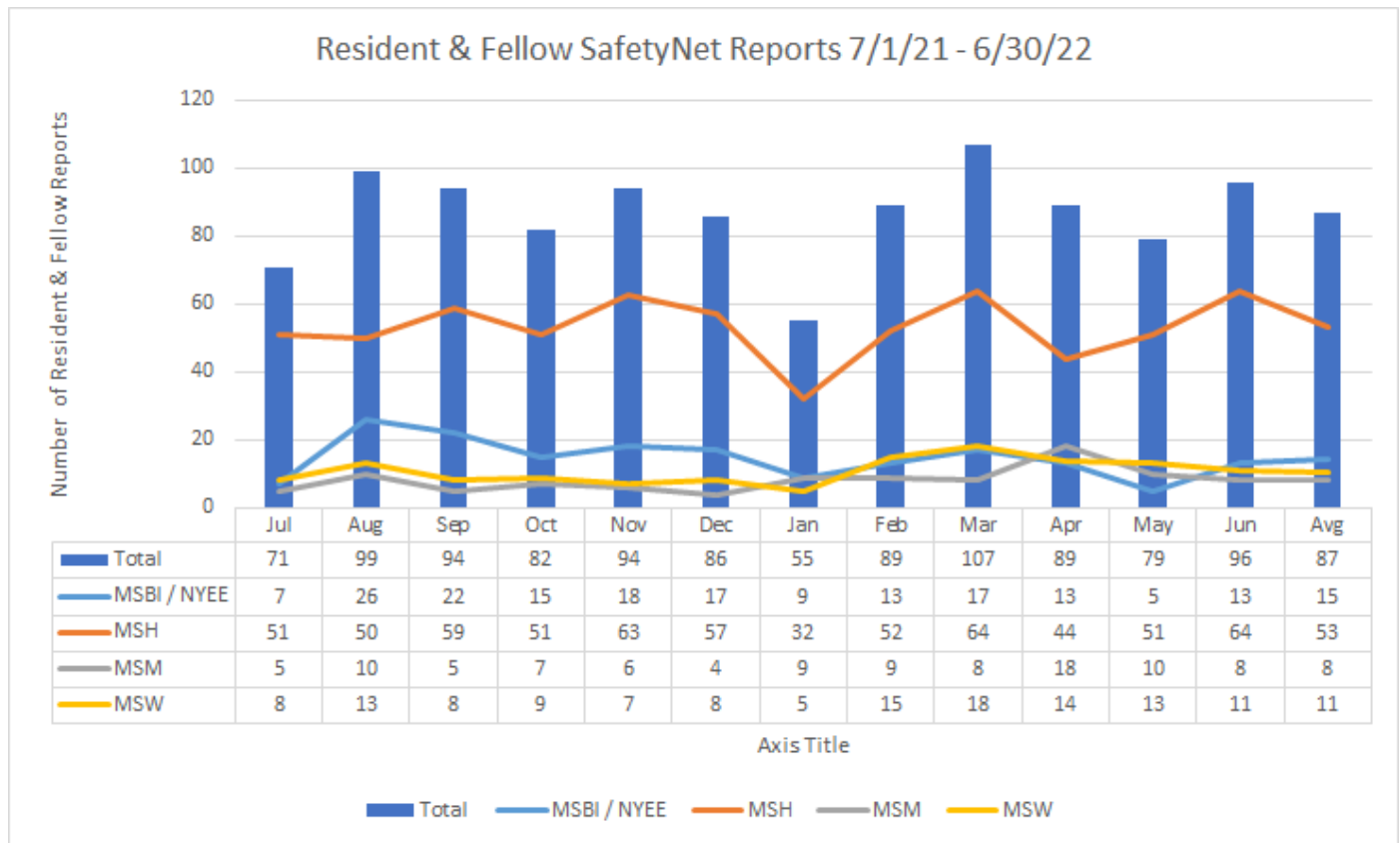
I entered a report and want to know what happened

A spreadsheet of all residents and fellow entered reports has been posted on New Innovations. You can find your report and the name of the contact(s) for who is handling the case. If the case went to a root cause analysis, the results of the root cause analysis can be found in the spreadsheet as well.

Residents, fellows and faculty are always encouraged to reach out to Daniel Steinberg (MSBI/NYEEI/MSMW) or Brijen Shah (MSH) with any questions.