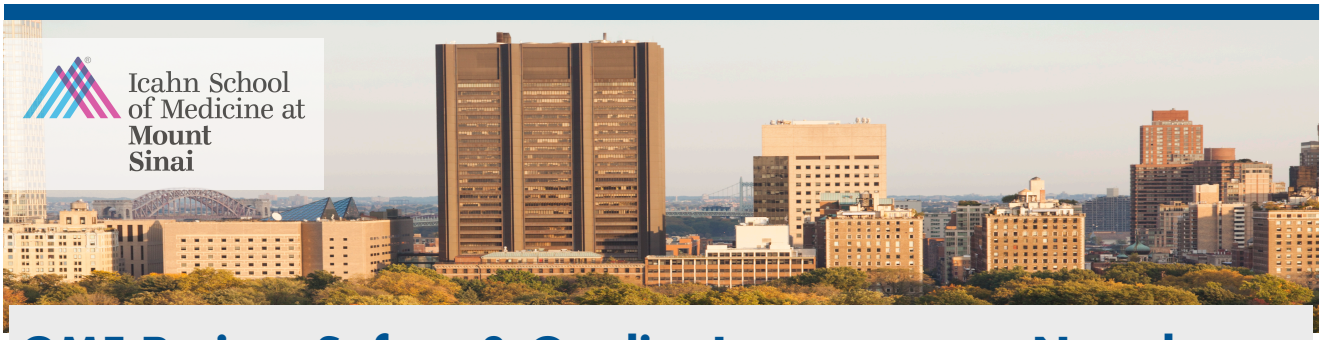


GME Patient Safety & Quality Improvement Newsletter

Highlighting A Resident Safety Project.

Caroline Black, MD

In this issue we highlight the work of Dr. Caroline Black, a pediatric emergency medicine fellow, who created a patient safety project to increase teamwork (cont'd p.2)

Great Catch Award Recipient

Dr. Sonali Tatapudy, MD & Dr. Scott Jelinek, MD, are residents in Pediatrics at the Mount Sinai Hospital. (cont'd p.3)

ACGME Healthcare Disparities Learning Collaborative

The Office of Graduate Medical Education was accepted to the inaugural ACGME Healthcare Disparities Learning Collaborative to improve the clinical learning environment. (cont'd p.4)

Get Ready for CLER

The Mount Sinai Hospital will have its third CLER visit on **Tuesday June 18 to Thursday June 20th**. (cont'd p.5)

Celebrate Risk Management Week

This year's theme is **"Leaders in Safe and Trusted Healthcare."** (cont'd p.6)

Message From Dr. Brijen Shah, MD

Associate Dean for GME in QI/Patient Safety, Mount Sinai Hospital

Dear Resident, Fellows, and Program Directors,

In this issue of the Newsletter, we are excited to share another resident Great Catch and highlight one resident driven Patient Safety project which received a Blue Ribbon award at the recent Institute for Medical Education Research Day. We also introduce you to the Health Care Disparities and Quality Improvement project that we are undertaking as part of our participation in the ACGME Learning Collaborative.

Congratulations to the residents and fellows who are graduating this June and special thanks to those who have given their time to our RCA committee, the House Staff QI committee and any resident/fellow who has given their energy to making some aspect of our hospital safer and better for patients and families. We hope that you will be advocates for safe, high quality and high value care in your future.

Sincerely,

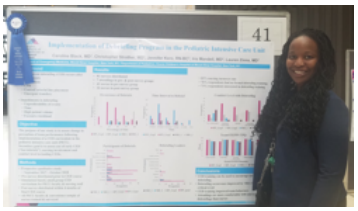
Brijen J. Shah, MD
Associate Dean for GME in QI/Patient Safety,
Mount Sinai Hospital

Highlighting A Resident Safety Project

Caroline Black, MD *Pediatric Emergency Medicine Fellow*

In this issue we highlight the work of Dr. Caroline Black, a pediatric emergency medicine fellow, who created a patient safety project to increase teamwork, which is one of our MSHS goals. Dr. Black's poster was awarded an IME Blue Ribbon for the high quality of work at the recent IME Medical Education Research Day.

Implementation of a Debriefing Program in the Pediatric Intensive Care Unit.



Patient safety is a hot topic in all areas medicine. Currently debriefings, brief discussions following a clinical event that allows team members to review the case, discuss what went well and identify opportunities for improvement, have been emphasized and promoted in the literature as an essential tool for teaching nontechnical skills (teamwork, communication, leadership). Guidelines set by the American Heart Association, American Academy of Pediatrics and European Resuscitation Council recommend routine use of debriefing in clinical practice as it provides critical reflection that promotes communication, understanding to enhance team performance and improve patient safety. However, there are many challenges to accomplishing debriefs in medicine, such as unpredictability of when events occur and inability to block off short interval of time due to high patient volume or excessive work load.

In partnership with the pediatric intensive care unit of Kravis Children's Hospital, my team and I executed a prospective qualitative improvement study implementing a simulation-based clinical event debriefing (CED) curriculum to PICU faculty and nurses from September 2017 to October 2018. During this time period, pre- and post-implementation surveys were distributed to PICU faculty and nurses prior to and following completion of CED training. The surveys comprised background information on current debriefing occurrence, leadership, comfort level in leading CEDs as well as perception of teamwork through TeamSTEPPS Teamwork Perception Questionnaire (T-TPQ), a validated, evidence-based assessment tool with the goal of improving patient outcomes by cultivating increased communication and teamwork skills among healthcare professionals. Through CED training, we hoped to see increased "hot" debriefings, debriefings occurring within 6 hours post-event, as well as an improvement in perception of team performance and communication during clinical events.

Our study saw an increase in CED occurrence as well as an increase in debriefings within 6 hours of clinical events ("hot debriefs") following implementation of formal CED training. Although both PICU faculty and nurses were trained in CED, PICU faculty had the greatest comfort level with debriefing and were perceived to be debriefing leaders 100% of the time by nursing and faculty.

As for perception of teamwork in the 5 domains of T-TPQ (team function, leadership, situation monitoring, mutual support and communication), we saw the largest improvement in perception of leadership and situation monitoring amongst PICU nurses. PICU faculty showed no significant change in any domain, although, scores in all 5 domains were high signifying positive perception in the unit overall.

Formal CED training can be used as a tool to encourage, not only increased debriefing, but positive team behaviors and awareness of patient safety. Though we focused on improving teamwork through debriefings amongst PICU faculty and nurses, debriefing is an interdisciplinary discussion that includes house staff (residents, fellows) and other health professionals (respiratory therapist, anesthesiologist, social work, etc.) present during events. Involvement in debriefings, especially during training years, cultivates development of effective teamwork, communication, leadership skills, acquired through role-modeling and active participation.

As a fellow, I have been a part of debriefs in the pediatric emergency department as both leader and participant and attest to its benefits. I learned to listen and facilitate nonthreatening conversations amongst my team. Through debriefings we've discovered systematic issues such as a sepsis alert malfunction within the EMR in which 18-year old patients were inadvertently left off the sepsis alert pathway and did not trigger sepsis on presentation with concerning vitals. This conscious awareness and discussion allowed for the department to effectively assess and readily implement changes to our alert system. Given the consensus- and evidence-based recommendations, debriefing should be incorporated into daily practice as it can improve physician competence while promoting a culture of safety.

Great Catch Award Recipient

Sonali Tatapudy, MD PGY-3 Pediatrics, Mount Sinai Hospital.
Scott Jelinek, MD PGY-1 Pediatrics, Mount Sinai Hospital

As part of my teaching rotation, I was asked to help orient the interns to the well baby nursery as part of my teaching rotation. That morning, we noticed that three newborns were initially noted to be Coombs negative on laboratory testing. However they were clinically jaundiced during our exam and flagged as having ABO incompatibility on further chart review.

Scott Jelineck, pediatric intern on call in the WBN that day, informed me about this error. Together we informed the lab, requesting the bloodwork, including Coombs testing, bilirubin, and hematocrit, be repeated. The results of the new blood work showed the patients were Coombs positive.

By following our clinical judgement, we were able to avoid any apparent harm. We started the patients on phototherapy in a timely manner.

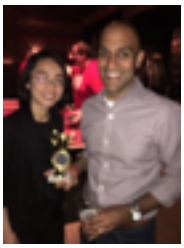
While the recognition we have received from this award was not our intention, it is a helpful way to affirm that our clinical judgment was accurate. It reinforced the importance of trusting our clinical skills as well as the importance of thorough chart review, even on "routine" admissions!

ACGME Healthcare Disparities Learning Collaborative

The Office of Graduate Medical Education was accepted to the inaugural ACGME Healthcare Disparities Learning Collaborative to improve the clinical learning environment. This opportunity brought together residents from both the Mount Sinai Hospital and Mount Sinai Beth Israel with a robust hospital leadership team to discuss our greatest opportunities in improving healthcare disparities in the patients we see every day.

To kick off this momentous endeavor, a team representing Mount Sinai attended a three-day training with training programs around the country in Chicago in February. There, we learned that according to the 2018 national report for the Clinical Learning Environment Review (CLER) Program, few clinical learning environments had formal strategies to address healthcare disparities or even have a systematic approach to identifying variability in the care provided to the clinical outcomes of their patient populations at risk for healthcare disparities. Every institution participating in the collaborative was challenged to propose a strategic plan to connect the institution's mission of addressing healthcare disparities to the care being delivered and outcomes in its population. In addition, each institution will conduct quality improvement project to address one aspect of healthcare disparities.

Our primary project involves an evaluation of trainee clinics for observable healthcare disparities - Internal Medical Associates (IMA) and General Medicine Associates (GMA) for the Mount Sinai Hospital and Mount Sinai Beth Israel internal medicine residents, respectively. Both sites will examine how the clinics collect granular race and ethnicity data (RED) and sexual orientation and gender identity (SOGI) data. We are currently in the assessment phase and will move toward problem and solution identification in the summer with hope to implement an intervention in the late fall. To support the quality improvement projects in the clinics, we are also working with data analysts to create dashboards displaying health metrics mapped to various SOGI and RED information to show us where healthcare disparities lie.



We hope that this project will expand beyond the internal medicine clinics and into all areas of medicine and surgery because healthcare disparities have no bounds. We are fortunate to have strong hospital and GME leadership to support trainee's initiatives. We encourage all residents who are interested to be involved to contact us (rui.jiang@mssm.edu or Emily.hertzberg@mssm.edu).

Get Ready for CLER!

Seven site visits will meet with residents, faculty, and program directors over three day. They will conduct walk rounds in the inpatient, ER, and operating areas.

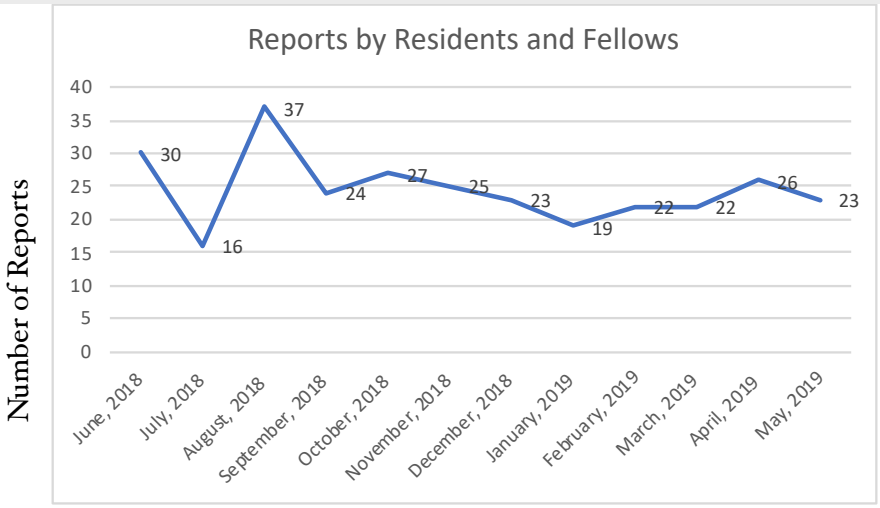
What do you need to know:

- Review the two page information handout on CLER (coming soon via email)
- Know the hospital patient safety and QI priorities
- Be able to describe how you participate in patient safety and hospital QI activities
- Actively participate in transitions of care.

We will need participants for our resident sessions and senior residents to serve as walking escorts. Look out for calls for participation from your program.

We look forward to your participation for a successful visit.

MERS - Event Reporting



Report a Patient Safety Event

mers.mountsinai.org

RCA Committee

Congratulations to the RCA Members graduating this year!

Kathleen Li, MD
Ashley Whisnant, MD
Ruth Nir, MD
Suhavi Tucker, MD
Anish Parikh, MD
Nagendra Madisi, MD
Judah Sueker, MD
Stephanie Le , MD
Sameer Lakha, MD
Charles Snyder, MD

Please be on the look out for an email to submit an application to join the RCA Committee.

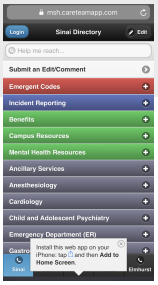
Celebrate Risk Management Week

This year's theme is **"Leaders in Safe and Trusted Healthcare."**
To promote the department's various patient safety and risk management activities, employees are invited to lectures and presentations and stop by the informational tables.

Date	Event	Location
Monday, June 17th at 2pm - 4pm	**"Mock Trial"Presented byIrving Hirsch, Esq., Wilson, Elser, Moskowitz, Edelman & Dicker,**	**Annenberg Building 5th Floor Rm 5-09 Mount Sinai Hospital (live webcast to other sites)**
Friday, June 21st at 1pm – 3pm,	**" When Words and Actions Matter Most: The Case for CANDOR" Presented by *Timothy McDonald, MD, MBA, JD***	**Hatch Auditorium, The Mount Sinai Hospital (live webcast to other sites)**
Friday June 21st at 1pm – 3pm	***"Examination at Trial of the Defendant Physician" Presented by Nick Marotta, Esq., Aaronson, Rappaport, Feinstein & Deutsch, LLP***	**Muhlenberg 4th Floor Auditorium, Mount Sinai St. Luke's (later webcast to other site)**
Monday, 4/17 and Tuesday 4/18 10am – 2pm	**Informational Tables**	**Guggenheim Pavilion, Mount Sinai Hospital**

Staff are encouraged to learn more about how the Risk Management Department contributes to the patient safety and be eligible for fun

Sinai Care-Team App



Dear Residents/Fellows:

At the start of the 2018-19 Academic Year we launched the Sinai CareTeam App, a web-based smartphone app directory to facilitate greater inter-professional communication and want to again encourage you to both download the app and share your feedback by completing a brief form found here as we look at continued ways to improve the app and increase utilization. We will shortly begin the process of developing content for MSBI, MSSLW and NYEEIMS.

We hope that many of you who have not already done so will download the app and use it; we would greatly appreciate your feedback as we work to continue to improve its effectiveness.

Please reach out to mountsinaiqi@gmail.com for any questions you may have about the app and/or use the App's **Submit Edit/ Comment** functionality for any additions or corrections you wish to submit.

Kathleen Li, MD
PGY4, MSH Emergency Medicine

Suhavi Tucker, MD
PGY3, MSH Internal Medicine