Standardizing Supervision Signifies and Supports Safety (5S)
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INITIATIVE OVERVIEW
At OHSU, our clinical units vary in their ability, approach and capacity for addressing safety and quality. And the extent that house officers are involved with these efforts ranges from "nowhere in sight" to "residents drove the effort."
OHSU has tried to rectify this situation through a number of initiatives but more innovative approaches are needed to successfully address resident engagement and the variable approach to safety and quality noted above.

1. Our principal strategy is to create a Standardized, Competency-based Supervision Tool tied to ACGME Milestone achievement levels that will assist in critical entrustment decisions that drive both competency-based educational progress and promote patient safety. Rather than rely on the subjective judgment of individual faculty to make ad hoc decisions about the ability of each person they supervise, this tool will provide a structured means for learners to gain appropriate autonomy. The tool and its associated rubric will improve efficiency and reduce waste with regards to educational effort. It will also provide a common pathway across all programs for faculty to "sign off" on residents' competencies. Team members will verify the pertinent skills of residents through a transparent dashboard to ensure that nobody assumes or mistakes the skills of a given trainee. This intentional standardization of resident supervision holds great promise to enhance patient safety, improve the quality of care and fundamentally change our clinical learning environment. It will also increase efficiency and allow our residents to be more involved in procedures and patient care activities once their competency has been demonstrated (i.e., less missed opportunities). If the pilot is effective, it will be disseminated widely to other GME programs.

2. In addition, we will implement "Mini-Gembas" so that residents in one program observe how others work. Each learner will experience clinical systems separate from their daily routine, including teaching and work rounds, quality team report outs and huddles. We expect these exercises will improve daily work flow, shared decision making, and team integration within and across disciplinary and professional silos. Rotating residents will serve as "temporary guest workers," with the purpose of providing an outsider's perspective on improvement. Further, each resident will meaningfully participate as a member of an interprofessional team in a safety or QI project selected by another discipline.

3. A third idea we want to explore is the creation of a Patient Safety and QI Bootcamp. After an initial pilot phase with refinements, we anticipate making this a required experience for all residents.

4. Finally, we will initiate a pilot to Reimagine Rounds in which data transfer is replaced by discussion of safety events, adding value, patients' experiences and work flow. Teams will "round as if the learning environment is a patient" so that pertinent safety data and QI vital signs are discussed daily.

MAJOR GOAL
The two major goals we want to accomplish with our ideas are to (1) systematically increase resident engagement in quality and safety projects occurring within our health care system and (2) standardize the approach to both safety and quality across our programs, including curricular content, skill sets achieved and the decision to allow degrees of autonomy.

IMPACT ON PATIENT CARE
A systematic approach to standardizing supervision will ensure that house officers safely increase their autonomy as they progress towards independent practice by the time they are finished with their training. All stakeholders, including patients and the nursing staff, will be assured that house officers are only allowed to practice at a level commensurate with their skills.

EVALUATION / MEASUREMENT STRATEGY
We will use a logic model framework (Figure 1) that will characterize inputs (resources) needed for each activity (e.g., staff time and materials). We will also track outputs, including products and participation, and we will track both intended and unintended outcomes (as well as positive and negative ones) that occur as a result of our activities (e.g., changes in knowledge, awareness, skills, attitudes, behavior, decision-making & institutional policies).

Figure 1. Program Evaluation Logic Model Framework

We plan to develop a Competency-based Supervision Tool with GME program directors to attain both content and face validity. We will then pilot test and refine the tool using multiple observer techniques (three or more observers rating the same activities until agreement on scoring reaches kappa coefficients above 0.70). Once all items on the tool have reached this level of reproducibility, the instrument will be tested in three core GME programs before it is widely disseminated. To evaluate the Mini-Gembas, we will conduct focus groups to determine their impact on residents' abilities to work in teams as well as to identify and address "near misses" that may affect patient safety. Evaluations for the Patient Safety & QI Bootcamp and Reimagining Rounds will be developed as these activities are explored.

CONTRIBUTION TO THE LEARNING ENVIRONMENT
Our project will contribute positively to the clinical learning environment by increasing resident engagement and standardizing our approach to safety and quality across our GME programs in a manner that is aligned with the strategic plan set forth by our senior leaders.

ACKNOWLEDGEMENTS
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