AAPL Certificate Program in Physician Leadership
Capstone Project Final Proposal

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Helping our Hospital See Clearly: Expanding the Reach of CLER

Background: The implementation of a single accrediting body for Graduate Medical Education requires changes in quality initiatives, milestones, research requirements, and program evaluation. As the first program to successfully transition from American Osteopathic Association (AOA) to Accreditation Council for Graduate Medical Education (ACGME), one challenge we faced was creating an academic platform for application of the six core competencies (Professionalism, Patient Safety, Physician Wellbeing, Care Transitions, Healthcare Quality and Supervision) of the Clinical Learning Environment. Educational requirements vary from accrediting body to accrediting body, and meeting these requirements is often something that is interwoven into each program's curriculum. As we transitioned from the AOA to the ACGME in Single GME, we soon-realized the importance of the Clinical Learning Environment Review (CLER). We strove to not only *educate* our students, residents and faculty about the principles of the Clinical Learning Environment, but also have them *embrace* those values and *act* on them to better themselves, their patients, and our hospital. Therefore, we created our CLER curriculum with the theme of Educate, Embrace, and Act. The curriculum, which is described below, has been largely successful in our program. However, CLER assesses not only individual residency programs but also the Sponsoring Institution (SI) itself. Therefore, about 18 months after implementation of our CLER curriculum in our Internal Medicine residency program, we decided to expand the curriculum hospital-wide. This capstone project focuses on the expansion of CLER to each hospital employee and the evaluation of its success.

Because CLER was a completely new term and concept to our residents and faculty as we transitioned to ACMGE, education played a major role in the creation of a curriculum. Although the six individual core competencies themselves were not novel to the members of our department, we felt it important to cover each substandard individually to ensure complete understanding of the standards. For the education portion, each Tuesday and Thursday during noon conference, the resident or attending lecturer ended lecture with the CLER Standard of the Day. The teacher presented a case, real or invented, that centered on one sub-standard of the six core-competencies. Each case involved the roles of patients and their families, students, residents, attending physicians, and ancillary staff in daily clinical practice, to stimulate discussion on that day's CLER standard. Also, during our monthly Morbidity and Mortality conference, the resident presenter used CLER standards of their choice to demonstrate constructive ways to improve the care provided. The discussion surrounding the CLER Standard of the Day was a way to *embrace* the concepts, and *action* often ensued following that discussion.

Six months after implementation of the above-described curriculum, residents were surveyed using a number scale that ranged from 1 (not at all) to 5 (very well). One hundred percent of residents responded. The survey asked how well they understood the six CLER standards prior to beginning the curriculum and one third of residents responded "not at all" or "kind of." Conversely, 88.9% of residents responded that the daily discussion of each sub-standard enhanced their understanding of the concepts, with two thirds of residents replying their understanding was enhanced "very well."

Our vision was that by expanding the CLER curriculum hospital-wide, more patients would ultimately be helped through enhanced understanding and implementation of patient safety and healthcare quality endeavor, not only in the GME department but throughout the hospital.

Methods:

The project began in November, 2017 at our hospital's annual Care Conference. This conference requires attendance for each hospital employee. Therefore, it presented a good opportunity to educate each employee on CLER. A resident, attending physician or myself gave a 10 minute presentation at each session of the Care Conference, describing what CLER is and how we implemented it in our program. We laid out the specific plans (described below) for expanding our Educate, Embrace and Act model hospital-wide.

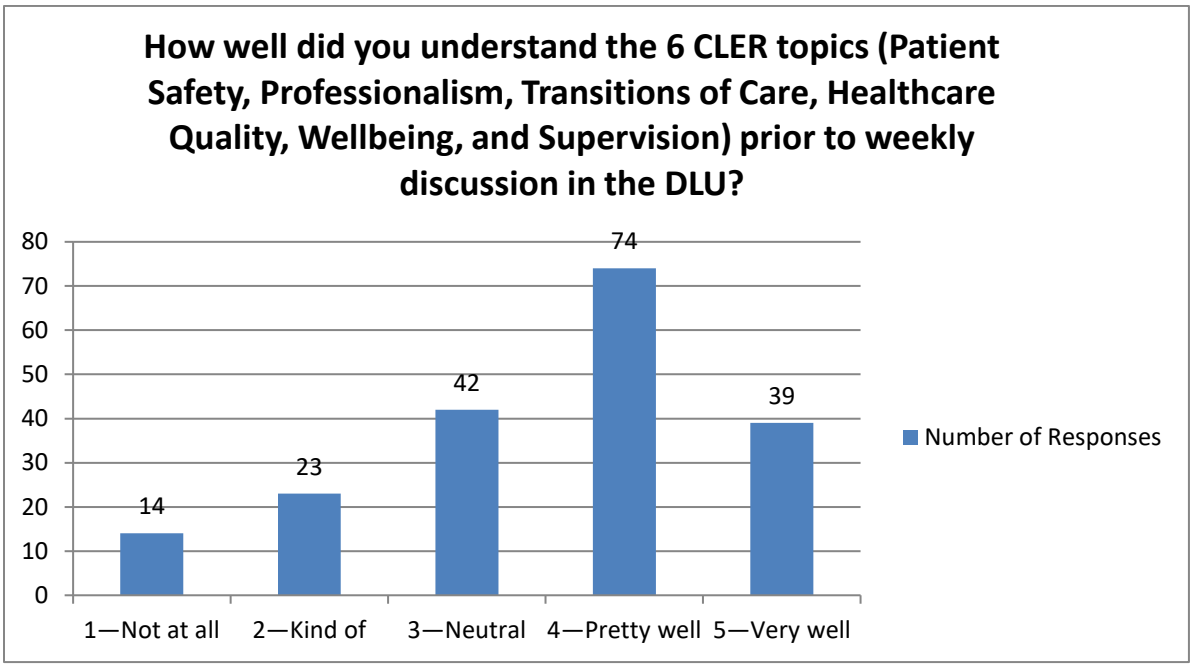
In January, 2018, we started the CLER Topic of the Week in our Daily Line Up (DLU). The DLU is a short, 10 minute part of each employee's day at our hospital. At some point during the day, each department is required to read and discuss the DLU together as a group. Because this is something required of every department and therefore every employee, we thought it would be a great way to reach everyone. As many of the individual CLER standards do not apply to most employees, we opted to use the broad pathways for discussion, instead of each individual substandard as we do in our department. For example, "PS Pathway 1: Reporting of adverse events, near misses/close calls, and unsafe conditions" would be the CLER Topic of the Week. We created examples that are relatable to different employees, such as Environmental Services, nursing staff, and maintenance personnel. The example of the week demonstrates the chosen pathway, and discussion questions were included after to spark feedback. (Please see Appendix A for a list of the CLER Topics of the Week and discussion questions).

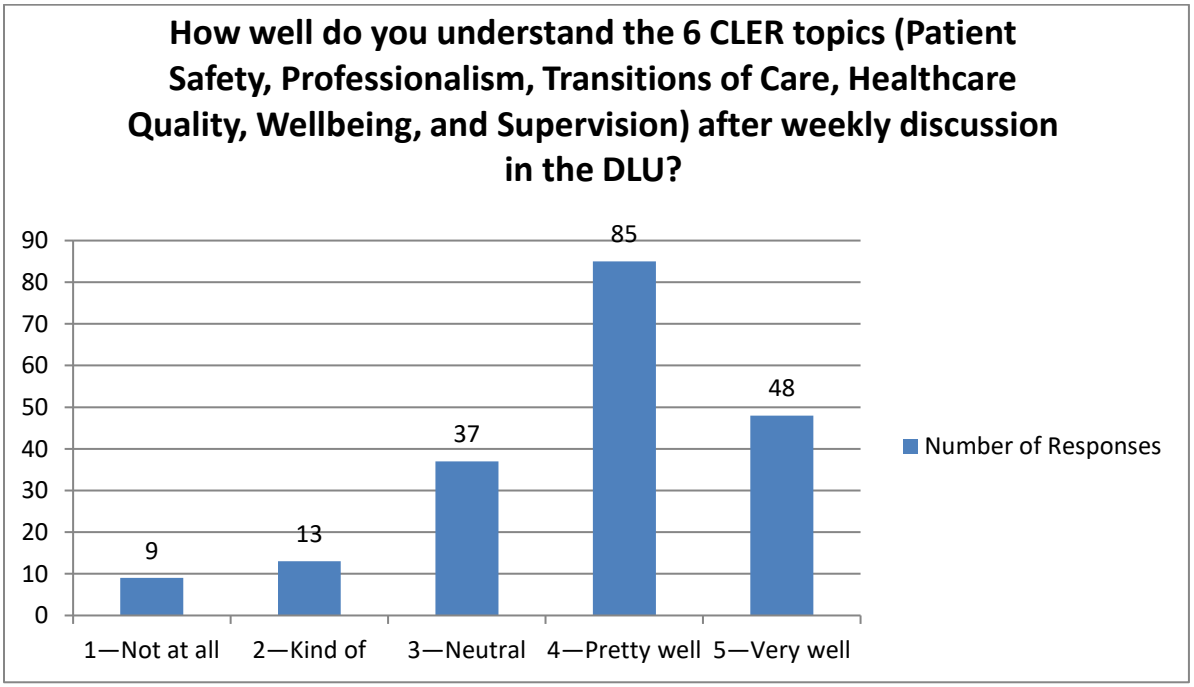
The goal was for the discussions to stimulate positive change in our hospital. One way to implement those changes is through "PICK" ideas. PICK stands for "Possible, Implement, Challenge, and Kabosh," language used to classify what happens to each idea after it is presented. Possible means that the idea has potential but may need modification. Implement means that the idea goes through without question. Challenge means that another employee challenges the integrity of the idea in its current form. Kabosh means that the idea will not move forward. Each employee is required to submit a certain number of "PICK" ideas each quarter, and our aim was to have many "PICK" ideas stem from discussion of the CLER Topic of the Week.

After six months of discussing the CLER Topic of the Week, we administered a survey in July and August, 2018. The survey was open for one month, and numerous reminders were sent out through hospital-wide email, reminders in the Daily Line Up, and postings on the hospital website. After the survey closed, we collected the below results.

Results:

Out of 1550 employees at MRHC, 192 responded to the survey, a 12.3% response rate. The employees were asked the following questions on a scale of 1-5: 1—Not at all, 2—Kind of, 3—Neutral, 4—Pretty well, and 5—Very well.





We then asked if any PICK ideas were submitted as a result of CLER discussions presented in the DLU. Of the 192 respondents, 31responded that yes, they had submitted a PICK idea. Of those who submitted a PICK idea, 10 involved Patient Safety, 4 involved Healthcare Quality and 3 involved Transitions of Care. 16 employees responded that the PICK idea had actually been implemented in their department.

Discussion and Impact:

The 2018 National Report of Findings for the second round of CLER site visits was recently released. Theme two states: "The clinical learning environments vary in how they align and collaborate with graduate medical education in developing the organization's strategic goals aimed at improving patient care. In many clinical learning environments, graduate medical education is largely developed and implemented independently of the organization's other areas of strategic planning and focus" (1). Our main objective with expanding our Educate, Embrace, and Act model for the Clinical Learning Environment Review hospital-wide was to: help our patients by making our hospital a safer, higher-quality environment. By educating not only the GME department in the CLER principles but reaching every member of the hospital, we hoped to bridge the gap between the GME department and the remainder of the Sponsoring Institution. We used a similar education model to the one used in our GME department to educate our residents and students about CLER. In order to make the principles more applicable to different members of the hospital staff, we used scenarios that were relatable to members of many departments (please see Appendix A). The survey conducted at the end of six months of weekly education assessed the understanding of the principles before and after the education, as well as changes that resulted through submitting PICK ideas.

Unfortunately, the response rate to the survey was very low, with only 12.3 percent of all employees responding. For that reason, the accuracy of the results may be compromised.

We hypothesized, based on the results of our prior survey of the resident physicians before and after CLER education, that weekly discussion of the CLER principles would enhance understanding of the concepts. Of the 192 employees who responded to the survey, 58 responded that they understood the principles "not at all," "kind of" or were "neutral" prior to CLER education. After CLER education, 59 employees responded that they understood the principles "not at all," "kind of" or were "neutral." Unlike the CLER education for our residents, the hospital-wide education did not make a difference in employee understanding of the six CLER competencies. There are a number of possible reasons for this. First, although we attempted to use scenarios that were applicable to many different job roles and responsibilities, those employees in non-clinical roles may not have had adequate experience with patients to make the education generalizable. Second, although the DLU is a required entity in each department, engagement in the discussion is undoubtedly variable. Third, because the CLER Topic of the Week was only one day per week in the DLU, those employees who were off on that day missed the education.

Although the education component was not successful in enhanced understanding, positive change did still come from the project. Thirty one employees said that they submitted a PICK idea as a result of the weekly discussion. About half of the PICK ideas (16) were implemented. Of the PICK ideas submitted, almost half involved Patient Safety (10 ideas) and Healthcare Quality (4 ideas). Because our primary goal was to improve patient safety and healthcare quality at our hospital, we believe that our project did make a constructive impact on patient care, despite not getting the results we desired.

Overall, we hoped to develop a model for hospital-wide CLER education and engagement that would be helpful not only to our hospital but to others across the country, particularly those engaged in Single GME transition. Unfortunately, our survey indicates that generalized, weekly education did not impact our hospital in the same way it impacted our residency program. More individualized, department-focused CLER education may be a better, more successful model. The weekly discussion did lead to department-specific changes, mostly involving patient safety and healthcare quality, although the number of PICK submissions and enactment were not as many as desired. More research, perhaps from the ongoing CLER site visits, is needed to learn the best way to educate not only trainees, but all hospital employees about the critical concepts of Patient Safety, Wellbeing, Healthcare Quality, Transitions of Care, Supervision and Professionalism.

References:

1. Co JPT, Weiss KB, Koh NJ, Wagner R; CLER Program. CLER National Report of Findings 2018: Executive Summary. Chicago, IL: Accreditation Council for Graduate Medical Education; 2018.

Appendix A:

CLER Daily Line Up Topic of the Week

Week of January 8th—12th:

A patient recovering from hip surgery is walking down the hall on 3 Tower with Physical Therapy. There is puddle of water in the floor that neither the patient nor physical therapist sees. The patient slips on the puddle and almost falls. Fortunately, PT is there to catch the patient and the patient does not get injured.

Questions for Discussion:
Does this count as a Patient Safety event? If you had seen the event take place, what would you do? Where would you report it?

CLER Tip of the Week:
Patient Safety Pathway 1: Reporting of adverse events, near misses/close calls, and unsafe conditions
Reporting is an important mechanism to identify patient safety vulnerabilities. A robust reporting system is essential for the success of any patient safety program.

Week of January 15th—19th:

You are an LPN working night shift on 2 South. You notice over a period of time that elderly patients who can't get up on their own have an increased number of bathroom accidents at night. You would like to do something to help the situation but are unsure who to go to or how best to address the problem.

Question for Discussion:
Would a Quality Improvement project be appropriate in this case? Who would you advise the LPN to go to for help? Addressing this issue would certainly help the patients, but could it also benefit the hospital? If so, how?

CLER Tip of the Week:
Health Care Quality Pathway 1: Education on quality improvement
Formal educational activities that create a shared mental model with regard to health care quality-related goals, tools, and techniques are necessary in order for health care professionals to consistently work in a well-coordinated manner to achieve health care quality improvement goals.

Week of January 22nd—26th:

You are a nightshift nurse on 4 Tower. You receive a very poor sign out from the day shift nurse. It is disjointed and you're not sure what is going on with the patient or what aspects of care you should

focus on. You ask the day shift nurse several questions to clarify and finally get the gist of what's going on with the patient.

Questions for Discussion:
Why is it important for nurses, LPN's, doctors, case managers, social workers, etc to discuss patients at each transition of care (i.e. shift change)? Do you have a standard way of telling your colleagues about your patients when others take over care? What kind of education do you get about transitions of care?

CLER Tip of the Week:
Care Transitions Pathway 1: Education on care transitions
Formal educational activities that create a shared mental model with regard to care transitions are necessary in order for residents/fellows to work in a consistently well-coordinated manner.

Week of Jan 29—Feb2:

You are a nurse in the SICU in July, and your patient needs an urgent central line. You see a new resident that you've never seen before begin to do the procedure. The attending physician isn't there yet. You are unsure if the resident is signed off to do the central line without supervision.

Questions for Discussion:
What should you do to determine if the resident is able to do the central line alone? (answer: there is a centralized list on Magnet to let you know which residents are signed off on which procedures).

CLER Tip of the Week:
Supervision Pathway 1: Education on supervision
Formal educational activities that create a shared mental model with regard to supervision are necessary for residents/fellows to work consistently in a safe manner.

Week of February 5—9:

You are part of the Maintenance team at MRHC working during the winter storm of 2018. You have put in many hours of overtime over the past week while other employees have time off. Your boss notices the next week that you are making simple mistakes and in a bad mood generally. Your boss recognizes the signs of burnout that are preventing you from doing your job well.

Questions for discussion:

What should your boss do? What are some of the signs of burnout? How do we at MRHC work to keep employee engagement and job satisfaction high and therefore decrease burnout?

CLER Tip of the Week:

Wellbeing Pathway 1: Clinical learning environment promotes well-being across the clinical care team to ensure safe and high quality patient care.

Week of February 12-16:

You are a brand new employee at MRHC. You worked in a very unprofessional environment at your last job. People dressed in sloppy clothes, used crude language, did not show up to work on time and left early, and were generally unpleasant to work with. This is why you looked for a new job.

Questions for Discussion:
What information will the new employee receive in orientation about Professional behavior? Why is it important to maintain a professional work environment at MRHC?

CLER Tip of the Week:
PR Pathway 1: Resident/fellow and faculty member [and employee] education on professionalism
Formal educational activities are essential to creating a shared mental model of professionalism that contributes to high-quality patient care.

Week of February 19-23:

You are a nurse in the MICU. You receive an order to start a new medication on a patient. You go to the patient's room and start the medication. However, a few minutes later, the alarms start beeping and the patient is crashing. You realize you gave the medication to the wrong patient.

Questions for Discussion:
What measures do we have in place to prevent the above situation from happening? What training do nurses receive in order to protect patients from human error? How does technology play a role in Patient Safety?

CLER Tip of the Week:
Patient Safety Pathway 2: Education on patient safety
Formal educational activities that create a shared mental model with regard to patient safety-related goals, tools, and techniques are necessary for health care professionals to consistently work in a well-coordinated manner to achieve patient safety goals.

Week of February 26—March 2:

You are a resident physician working at MRHC and are looking for a committee to work on. Someone suggests the Quality Committee. You think that would be a good way to help patients, so you sign up.

Questions for Discussion:
What does the Quality Committee at MRHC do? How does this committee help patients? What are some things your department can do to provide High Quality Healthcare, even if you're not directly involved in patient care?

CLER Tip of the Week:
HQ Pathway 2: Resident/fellow [and staff] engagement in quality improvement activities
Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Week of March 5—9th:

You are a night shift nurse and call the resident night float phone several times throughout the evening. The resident does not know anything about the patients and does not know how to answer your questions. You become frustrated as your patients have needs that are not being met.

Questions for Discussion:
What would you do in this case, if the physician does not know enough information about the patient to answer nursing questions? Why should this scenario never happen at night at MRHC on Hospitalist/Resident patients? (answer: the residents and hospitalists do a "sign-out" each evening and learn about the daytime patients, in order to care for them effectively at night)

CLER Tip of the Week:
Care Transitions Pathway 2: Resident/fellow engagement in change-of duty hand-offs
Standardized, effective, efficient hand-offs are a prerequisite for safe patient care.

Week of March 12—16th

You are a respiratory therapist in the ICU. You see an intern come in and change the ventilator settings on several intubated patients. The settings don't make sense to you and you are afraid the patients will get worse with them. When you ask the intern about it, he says that he is by himself in the ICU that day and is doing the best he can.

Questions for Discussion:
What should the RT do in this case? Why should this scenario not happen at MRHC? (Answer: the interns have hospitalist backup 24 hours a day. If the intern does not know what to do, he or she has constant access to the supervising physician)

CLER Tip of the Week:
Supervision Pathway 2: Resident/fellow perception of the adequacy of supervision
It is important to elicit resident/fellow perceptions as one indicator of the adequacy of supervision.

Week of March 19—23rd:

Questions for Discussion:
What are some things that MRHC does to promote the morale and wellbeing of its employees? (Answer: Annual Employee Christmas party and Fourth of July party, Biggest Loser Competition, holiday door competition this past Christmas, free meals in the cafeteria on special occasions, etc.)

CLER Tip of the Week:
Wellbeing Pathway 2: Clinical learning environment demonstrates specific efforts to promote the well-being of residents, fellows, and faculty members.

Week of March 26—30th:

You are a scrub tech in the cath lab and notice that a particular cardiology fellow always goofs off and acts unprofessionally during cases. You notice it's usually when the attending physician isn't present or isn't paying attention. You believe that the behavior is affecting the fellow's focus in the lab and potentially the patients' care.

Questions for Discussion:
What should the scrub tech do in this scenario? Is professionalism important for patient care? Why or why not?

CLER Tip of the Week:
Professionalism Pathway 2: Resident/fellow attitudes, beliefs, and skills related to professionalism
Resident/fellow attitudes, beliefs, and skills related to professionalism directly impact the quality and safety of patient care.

Week of April 2nd—6th:

You are a nurse on 2 South. Dr. No-good is taking care of one of your patients with heart failure. The patient has been in and out of respiratory distress throughout his stay, and the proper medications have not been started to address his breathing difficulties. You speak to Dr. No-good about your concern that the patient is not improving and seems to be getting worse. Dr. No-good says "you just leave the doctoring to me." A Code Blue is called the following day and the patient unfortunately dies. You are distraught and angry.

Questions for discussion:
What should the nurse do now, since she is concerned that the patient's care was not optimal? Do we at Magnolia value transparency in order to lead to a safer culture? (In other words, are we able to speak freely and without fear of consequences when mistakes occur, in order to make the environment safer for future patients?).

CLER Tip of the Week:
Patient Safety Pathway 3: Culture of safety:
A culture of safety requires a preoccupation with identification of vulnerabilities and a willingness to transparently deal with them. To this end, the safety system is perceived as fair and effective in bringing about needed improvements. The organization has formal mechanisms to assess attitudes toward safety and improvement in order to identify areas requiring intervention.

Week of April 9th—13th:

You are a new employee started at Magnolia. You have heard that a big focus is on the quality of health care provided and would like to learn more.

Questions for Discussion:
How often and when are the hospital's quality metrics reported? (Answer: There are weekly reports at M2 on Tuesday afternoons. All hospital leadership is there. Also, there is a quarterly Quality and Safety meeting during which the major quality measures are reported). If you would like to learn more about the quality initiatives of the hospitals and do not attend quality meetings, how would you find out more?

CLER Tip of the Week:
Healthcare Quality Pathway 3: Residents/fellows receive data on quality metrics.
Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Week of April 16—20th:

You are an attending physician caring for a patient on the medical regular floor. The patient begins to get worse and you think he needs to go to the ICU. You tell the nurse to transfer the patient and then leave for the day. The physician taking over care in the ICU has no idea who the patient is or why he needs ICU care.

Questions for discussion:
Why is it important for physicians, nurses, LPN's, respiratory therapy, physical therapy, sitters, and anyone else a part of the patient's care team to give a "hand-of" or "sign-out" when transferring a patient from one unit to another? What is the standard way of "handing off" a patient to another provider in your department?

CLER Standard of the Week:
CareTransitions Pathway 3: Resident/fellow and faculty member engagement in patient transfers between services and locations
Standardized, effective, efficient hand-offs are a prerequisite for safe patient care.

Week of April 23rd—27th:

You are a nursing student who is new to MRHC. You are told by a floor nurse to go start an IV on a patient. You have never done this before, but don't want to tell the nurse that as you are afraid it will affect your grade. The nurse says she is busy and can't go with you right now.

Questions for Discussion:
What should the nurse have done? How should supervisors (the nurse in this case) at any level or department work to ensure their staff has the resources they need to do their job well? Do you feel that there is adequate supervision in your department?

CLER Tip of the Week:
S Pathway 3: Faculty member perception of the adequacy of resident/fellow supervision
It is important to elicit faculty members' perceptions as one indicator of the adequacy of supervision.

Week of April 30th—May 4th:

Questions for discussion:
Is it important for your department and its employees to balance work with life outside of work? What kinds of things does your department do to promote the well-being of its employees? What does MRHC as an institution do to promote the well-being of its employees? (Answer: holiday tea, holiday dinner, July 4th family event, retirement parties, recent March Madness lunch)

Wellbeing Pathway 3: Clinical learning environment promotes an environment where residents, fellows, and faculty members can maintain their personal well-being while fulfilling their professional obligations.

Week of May 7—11:

You are an LPN working on 3Tower. A patient gets back from an orthopedic surgery and you take his vital signs. The patient's blood pressure is 170/55. However, you accidentally chart 70/55. You don't realize the mistake until the nurse comes rushing into the room to check on the patient after seeing the vital signs charted.

Questions for Discussion:
What should you do if you chart something incorrectly in the medical record? How could covering up unintentional mistakes like this one affect patient care?

CLER Tip of the Week:
Professionalism Pathway 3a: Faculty/ [Employee] Engagement in Training on Professionalism.
Faculty members [and employees] follow the clinical site's policies, procedures, and professional guidelines when documenting in the electronic medical record.

Week of May 14—18th:

You are an occupational therapist working with a patient on 3 Tower. The patient slips on the floor that has been freshly mopped and falls. The patient does not sustain serious injury, but you are concerned that the next patient might be badly hurt. You enter a quality concern about the floor being wet with no caution sign in place.

Questions for Discussion:
Once the quality concern is entered, how do you know that it is being followed up? How do you receive feedback on the processes that change as a result of quality concerns?

CLER Tip of the Week:
PS Pathway 4: Resident/fellow/ [employee] experience in patient safety investigations and follow-up
Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

Week of May 21—25th:

Questions for Discussion:
What are some of the Quality Improvement projects actively underway at Magnolia? (Answer: pneumonia mortality, CHF readmissions, sepsis improvement, etc.) Once a Quality Improvement project is implemented, how do we keep the momentum for the project to continue successfully?

CLER Tip of the Week:
HQ Pathway 4: Resident/fellow/ [employee] engagement in planning for quality improvement
In order to understand quality from a systems-based perspective, it is necessary to be familiar with the entire cycle of quality improvement (QI) from planning through execution and reassessment.

Week of May 28—June 1st:

It is July at Magnolia and you are a new intern in the hospital. On your first day, you are supposed to sign out the patients you saw to the night team taking over. However, you aren't sure what information is important and what isn't.

Questions for Discussion:
How do new employees in your department learn the proper way to sign out patients at shift change? What is the process for oversite of hand-off-of-care in your department? Why is it important to ensure sign out is accurate and efficient?

CLER Tip of the Week:
CT Pathway 4: Faculty member/ [supervisor] engagement in assessing resident-/fellow-related patient transitions of care

Evaluation through direct observation of residents/fellows/[employees] by faculty members [and supervisors] is required to ensure residents'/fellows' abilities to perform standardized, effective, efficient hand-offs.

Week of June 4—8th:

You are a nurse working at night. Your patient needs a central line placed because his blood pressure is low. You call the night team, and the intern says that the supervising doctor and upper level resident are busy, but that he is available to put in a central line. You know that it is early in the year and are not sure the intern should be performing the procedure alone.

Questions for discussion:
What should the nurse do to find out if the intern is able to perform the procedure alone? (Answer: There is a list on Magnet describing which residents can perform which procedures). If the resident is not signed off to perform the procedure, what should the nurse do? (Answer: Call the supervising/attending physician).

CLER Tip of the Week:
S Pathway 4: Roles of clinical staff members other than physicians in resident/fellow supervision: Awareness of and actions to ensure appropriate resident/fellow supervision are essential to patient safety.

Week of June 11—15th:

You are a new employee at MRHC. You have heard that MRHC has a Wellness Program to help promote healthy lifestyles for employees. You are interested in learning more.

Questions for Discussion:
What does MRHC do to promote wellness for its employees? (Answer: Biggest Loser weight loss competitions, healthy recipes on Magnet, step challenges, Wellness Classes taught by physicians, free yearly health screenings).

CLER Tip of the Week:
WB Pathway 4: Clinical learning environment demonstrates system-based actions for preventing, eliminating, or mitigating impediments to the well-being of its [employees].

Week of June 18—22th:

You are a patient on 2 South. You notice that your resident physician has dark bags under her eyes and is yawning continually. You ask her how many hours she has worked this week, and she replies 100 hours. You are immediately worried about the doctor, as well as the care you have been receiving!

Questions for Discussion:
Why should this scenario never happen at MRHC? (Answer: the resident physicians are only allowed to work a maximum of 80 hours a week). How does the leadership know that the residents are not going over that hour limit? (Answer: the residents are required to report duty hours weekly. Any time an hour violation happens, this is reported to the leadership of GME and the hospital, and action taken to prevent it from happening again in the future).

CLER Tip of the Week:
PR Pathway 3b: Culture of honesty in reporting
Prevention of fatigue-related harm to patients can only be accomplished in a culture in which candid reporting of duty hour-/fatigue management-related issues occurs.

Week of June 25—29th:

You are listening to the daily line up being read in your department. As you daydream, you realize it's the day for PICK ideas. You also realize it's near the end of the year and you haven't met your quota for PICK ideas.

Questions for Discussion:
Why are employees in each department required to submit PICK ideas? How are PICK ideas useful for Patient Safety? Please name an example of a PICK idea from your department this year that has improved the safety of our patients, either directly or indirectly.

CLER Tip of the Week:
PS Pathway 5: Clinical site monitoring of [employee] engagement in patient safety
Residents/fellows are a vital component to the continual improvement of clinical care to patients; their participation in patient safety activities is essential.