SBP Competencies and Milestones

University of Colorado GME Quality and Safety Academy Faculty Series

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Internal Medicine and IM Subspecialties

Not Yet Assessable	Critical Deficiencies			Ready for unsupervised practice	Aspirational
	Ignores a risk for error within the system that may affect the care of a patient Ignores feedback and is unwilling to change behavior in order to reduce the risk for error	Does not recognize the potential for system error Makes decisions that could lead to errors that are otherwise corrected by the system or supervision Resistant to feedback about decisions that may lead to error or otherwise cause harm	Recognizes the potential for error within the system Identifies obvious or critical causes of error and notifies supervisor accordingly Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk Willing to receive feedback about decisions that may lead to error or otherwise cause harm	Identifies systemic causes of medical error and navigates them to provide safe patient care Advocates for safe patient care and optimal patient care systems Activates formal system resources to investigate and mitigate real or potential medical error Reflects upon and learns from own critical incidents that may lead to medical error	Advocates for system leadership to formally engage in quality assurance and quality improvement activities Viewed as a leader in identifying and advocating for the prevention of medical error Teaches others regarding the importance of recognizing and mitigating system error
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐

10. Recognizes system error and advocates for system improvement. (SBP2)

Comments:

Surgery

Systems-Based Practice 1: Patient Safety and Quality Improvement

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of common patient safety events	Identifies system factors that lead to patient safety events	Participates in analysis of patient safety events (simulated or actual)	Conducts analysis of patient safety events and offers error prevention strategies (simulated or actual)	Actively engages teams and processes to modify systems to prevent patient safety events
Demonstrates knowledge of how to report patient safety events	Reports patient safety events through institutional reporting systems (simulated or actual)	Participates in disclosure of patient safety events to patients and families (simulated or actual)	Discloses patient safety events to patients and families (simulated or actual)	Mentors others in the disclosure of patient safety events
Demonstrates knowledge of basic quality improvement methodologies and metrics	Describes local quality improvement initiatives (e.g., infection rate, hand hygiene, opioid use)	Participates in local quality improvement initiatives	Demonstrates the skills required to identify, develop, implement, and analyze a quality improvement project	Creates, implements, and assesses quality improvement initiatives at the institutional or community level
☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐

Comments:

Not Yet Completed Level 1 ☐

Ob-GYN

Patient Safety and Systems Approach to Medical Errors: Participate in identifying system errors and implementing potential systems solutions — Systems-based Practice

Level 1	Level 2	Level 3	Level 4	Level 5
Recognizes limitations and failures of a team approach (e.g., hand-offs, miscommunication) in health care as the leading cause of preventable patient harm	Demonstrates knowledge of institutional surveillance systems to monitor for patient safety (e.g., surgical site infection, medical error reporting) Participates in "time-out" Appropriately utilizes check lists to promote patient safety (e.g., medication reconciliation) Demonstrates knowledge of the epidemiology of medical errors and the differences between near misses, medical errors, and sentinel events	Participates in patient safety reporting and analyzing systems Participates in team drills Demonstrates knowledge of national patient safety standards, as well as their use/application in the institution	Reports errors and near-misses to the institutional surveillance system and superiors Recognizes when root cause analysis is necessary, and is capable of participating in root cause analysis Actively participates in quality improvement (QI)/patient safety projects	Contributes to peer-reviewed medical literature Organizes and leads institutional QI/patient safety projects
☐　　☐	☐　　☐	☐　　☐	☐　　☐	☐

Comments:	Not yet achieved Level 1 ☐

Pediatrics

SBP2. Advocate for quality patient care and optimal patient care systems

Not yet Assessable	Level 1	Level 2	Level 3	Level 4	Level 5
	Attends to medical needs of individual patient(s); wants to take good care of patients and takes action for individual patients' health care needs	Demonstrates recognition that an individual patient's issues are shared by other patients, that there are systems at play, and that there is a need for quality improvement of those systems; acts on the observed need to assess and improve quality of care	Acts within the defined medical role to address an issue or problem that is confronting a cohort of patients; may enlist colleagues to help with this problem	Actively participates in hospital-initiated quality improvement and safety actions; demonstrates a desire to have an impact beyond the hospital walls	Identifies and acts to begin the process of improvement projects both inside the hospital and within one's practice community
	Example: *Sees a child with a firearm injury and provides good care.*	*Example:* *A physician notes on rounds, "We have sent home four-to-five firearm-injury patients and one has come back with repeated injury. We need to do something about that."*	*Example:* *The physician works with colleagues to develop an approach, protocol, or procedure for improving care for penetrating trauma injury in children and measures the outcomes of system changes.*	*Example:* *The physician attends a hospital symposium on gun-related trauma and what can be done about it and then arranges to speak on gun safety at the local meeting of the parent-teachers association.*	*Example:* *Upon completion of quality improvement project, the physician works on new proposed legislation and testifies in City Council.*
☐	☐　　☐	☐　　☐	☐　　☐	☐　　☐	☐

Comments:

PMR

SBP 3. Patient safety: Understands ways to improve health care safety through participation in identifying system errors and implementing potential systems solutions					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4 (Graduation Target)	Level 5 (Aspirational)
	Recognizes the impact of process and systems failures on patient safety	Participates in established safety initiatives (e.g., use of approved abbreviations, isolation precautions, hand washing) Applies structured process(es) to foster clear, concise, accurate, and specific communication during patient hand-offs	Identifies health system factors that increase risk for errors, (e.g., errors in the Electronic Medical Record, lack of health information exchange) Utilizes existing processes and procedures for reporting problematic events	Partners with others in activities to improve patient safety Learns from critical incidents or systems failures that have impacted patient safety	Leads systems-level patient safety interventions Proactively identifies system failures and risks for medical errors
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Comments:					

Systems-Based Practice. The resident is demonstrating satisfactory development of the knowledge, skill, and attitudes/behaviors needed to advance in residency. He or she is demonstrating a learning trajectory that anticipates the achievement of competency for unsupervised practice that includes the delivery of safe, timely, equitable, effective, and patient-centered care.

_____Yes   _____No

Comments, please provide when "No" is checked:

Psychiatry

SBP1. Patient Safety and the Health care Team A: Medical errors and improvement activities B: Communication and patient safety C: Regulatory and educational activities related to patient safety					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Differentiates among medical errors, near misses, and sentinel events 1.2/B Recognizes failure in teamwork and communication as leading cause of preventable patient harm 1.3/C Follows institutional safety policies, including reporting of problematic behaviors and processes, errors, and near misses	2.1/A Describes the common system causes for errors 2.2/B Consistently uses structured communication tools to prevent adverse events (e.g., checklists, safe hand-off procedures, briefings) 2.3/C Actively participates in conferences focusing on systems-based errors in patient care	3.1/A Describes systems and procedures that promote patient safety	4.1/A Participates in formal analysis (e.g., root-cause analysis, failure mode effects analysis) of medical errors and sentinel events 4.2/C Develops content for and facilitates a patient safety presentation or conference focusing on systems-based errors in patient care (i.e., a morbidity and mortality [M&M] conference)	5.1/A Leads multidisciplinary teams (e.g., human factors engineers[1], social scientists) to address patient safety issues 5.2/A, C Provides consultation to organizations to improve personal and patient safety
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Comments:					
Footnotes: [1] Human Factors Engineering (HFE) is a framework for efficient and constructive thinking which includes methods and tools to help health care teams perform patient safety analyses (see: Gosbee J, Human factors engineering and patient safety, Quality and Safety in Health Care, 2002;11:352–354).					