RUTGERS HEALTH
Graduate Medical Education

PATIENT SAFETY AND QUALITY IMPROVEMENT POLICY

Section: 3.5
Section Title: Clinical Learning Environment
Approval Authority: GMEC
Approved: March 20, 2026
Policy Name: Patient Safety and Quality Improvement
Responsible Executive: DIO
Responsible Office: Office of Clinical and Health Affairs, Rutgers Health
Contact: Institutional Coordinator

1. **Reason for Policy**
   To establish and sustain a clinical learning environment in which residents and fellows are educated, empowered, and accountable to report and learn from patient safety events, participate in quality improvement (QI) and health equity work, and contribute to system-level improvements that reduce preventable harm and improve outcomes.

2. **Applicable ACGME Institutional Requirements**
   3.2 Learning and Working Environment

3. **Resources**
   i. Accreditation Council for Graduate Medical Education Institutional Requirements
   ii. Accreditation Council for Graduate Medical Education Common Program Requirements
   iii. Rutgers University Policies
   iv. New Jersey Board of Medical Examiners
   v. American Board of Medical Specialties

4. **Scope**
   This policy applies to applies to all residents and fellows in training at Rutgers Health.

5. **Definitions**
   i. Patient safety event: an incident, condition, or circumstance that could have resulted, or did result, in unnecessary harm to a patient. This includes adverse events, near misses, and unsafe conditions.
   ii. Adverse event: an injury or complication resulting from medical management rather than the underlying disease, which may or may not be preventable.
   iii. Near miss: A patient safety event that did not reach the patient and therefore did not cause harm, but had the potential to do so,
   iv. Unsafe condition: A circumstance that increases the likelihood of a patient safety event.
   v. Root cause analysis (RCA): A structured method to identify contributing factors and underlying system causes of a patient safety event and to develop actions that reduce the risk of recurrence.
   vi. Quality improvement (QI): Systematic, data-guided activities designed to bring about immediate improvements in health care delivery and outcomes (i.e. Plan-Do-Study-Act cycles).

vii. Health equity/health care disparities: Differences in health outcomes and health care access experienced by certain populations; QI work should include efforts to identify and reduce disparities
viii. Patient Safety Event Reporting System: The mechanism(s) used by each clinical site to report errors, adverse events, near misses, and unsafe conditions, including protected reporting outcomes

6. **The Policy**
   i. The Sponsoring Institution, through the DIO and GMEC, is responsible for oversight and documentation of resident and fellow engagement in patient safety and quality improvement activities across all participating sites. The institution will monitor compliance, review participation data, and ensure that each program provides meaningful opportunities consistent with ACGME institutional requirements.
   ii. Each program must maintain a clinical learning environment that is committed to patient safety, quality improvement, and accountability.
   iii. All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.
   iv. Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.
   v. It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

7. **Roles and Responsibilities**
   i. GMEC and DIO (Institutional Oversight): Ensure trainees have access to a patient safety event reporting system; provide institution-wide orientation resources on patient safety and QI; make available aggregated/summarized patient safety and quality data to programs; and monitor institutional compliance with ACGME requirements.
   ii. Program Directors and Faculty: Implement and document program-level patient safety and QI education; encourage and support reporting and participation without fear of reprisal; provide timely feedback to trainees on events and improvement work; and ensure trainees are appropriately supervised during all patient care activities.
   iii. Residents and Fellows: Complete required patient safety and QI training; report patient safety events (including near misses and unsafe conditions); participate in safety and QI analyses and improvement as assigned; and escalate clinical concerns when patient safety may be compromised.

8. **Confidentiality and Non-Retaliation**
   The Sponsoring Institution will ensure that all residents and fellows receive formal orientation at onboarding and at each participating site regarding:

   i. How to access and use the patient safety reporting system
   ii. How to escalate urgent safety concerns in real time, and

iii. Protections against retaliation for good faith reporting

Trainees have access to protected mechanisms to report errors, adverse events, near misses, and unsafe conditions, and may do so without fear of intimidation, retaliation, or adverse impact on their evaluation. Trainees may also report concerns to program leadership, the DIO, or the institutional patient safety office if they believe issues are not being addressed or if retaliation is a concern. Examples of reporting mechanisms include but are not limited to:

i. Confidential electronic event reporting system at all hospitals,
ii. Rutgers Health GME Anonymous Reporting Link
iii. The Rutgers Helpline at 833-RU-ETHICS (833.783.8442) (Rutgers Compliance Helpline)
iv. Rutgers Health GME Sponsoring Institution Ombuds
v. RWJBH Health System Corporate Compliance Hotline: 1-800-780-1140
vi. RWJBH Health System Corporate Compliance Reporting Link

9. **Patient Safety**

i. A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.
ii. The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. The program must have a structure that promotes safe, interprofessional, team-based care.
iii. Education on Patient Safety Programs must provide formal educational activities that promote patient safety related goals, tools, and techniques.
iv. Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the success of any patient safety program. Ongoing analysis and structured reflection are essential to developing competence in identifying contributing factors and implementing sustainable systems-based improvements.
v. Residents, fellows, faculty members, and other clinical staff members must:
    - know their responsibilities in reporting patient safety events at the clinical site;
    - know how to report patient safety events, including near misses, at the clinical site; and
    - be provided with summary information of their institution's patient safety reports.
vi. Each program must ensure that residents and fellows have structured opportunities to participate in root cause analyses (RCAs), apparent cause analyses, failure mode and effects analyses, or similar risk-reduction processes. Participation may include case review, contributing factor analysis, development of corrective actions, or implementation follow-up. Programs must document such participation.
vii. Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.
    - All residents must receive training in how to disclose adverse events to patients and families.
    - Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.
viii. Feedback and Experiential Learning. Programs and the institution will provide trainees with summary information from patient safety reporting (i.e. themes, trends, and improvement actions) and, when feasible, case-based feedback that "closes the loop" on events reported by trainees

ix. Interprofessional Participation in Patient Safety Structures. Programs should provide residents and fellows with opportunities to participate in institutional and departmental patient safety activities and committees, including safety committees, peer review processes, safety review meetings, morbidity and mortality conferences, transitions-of-care improvement initiatives, and root cause analyses (RCAs). Participation should promote interprofessional collaboration and systems-based learning.

x. Root cause analyses and related safety investigations are conducted within a protected, non-punitive framework. Residents and fellows who participate in or are interviewed as part of an RCA are afforded confidentiality protections consistent with institutional policy, and participation in such activities will not adversely affect evaluation or advancement.

xi. Site-specific reporting and escalation pathways. During onboarding to each participating site, trainees will receive instructions on how to report events and how to escalate urgent safety concerns in real time

10. **Quality Improvement**
    i. A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.
    ii. Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.
    iii. Access to Quality Metrics. Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts. The Sponsoring Institution will collaborate with participating sites to ensure that residents and fellows have access to relevant quality, safety, and equity data applicable to the populations they serve. Such data may include clinical outcomes, patient experience metrics, safety indicators, utilization measures, and disparity metrics.
    iv. Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.
        a. Residents must have the opportunity to participate in interprofessional quality improvement activities. This should include activities aimed at reducing health care disparities.
    v. Each program must ensure that every resident and fellow participates in at least one meaningful quality improvement activity during training. Meaningful participation could include defining or analyzing a problem, reviewing performance data, participating in a structured improvement methodology (e.g. PDSA cycle), evaluating outcomes, and reflecting on lessons learned.
    vi. Programs should provide trainees and faculty with relevant, timely, and understandable quality metrics and benchmarks (i.e. patient experience, safety indicators, clinical outcomes, and equity measures) for the patient populations they serve, consistent with institutional policies on confidentiality and data security.
    vii. Programs should support sharing QI results in scholarly output (i.e. conferences, posters, presentations, publications) and encourage sustainability planning when improvements are successful.

11. **Oversight**
    i. Programs must document trainee participation in patient safety and QI education and activities (i.e. orientation modules, conferences, RCA participation, QI projects) and review these activities at least annually. Program directors must report patient safety and QI participation and project summaries to the GMEC as part of the Annual Program Evaluation process.
    ii. The GMEC, or its designated subcommittee, will review and document institutional oversight of resident and fellow engagement in patient safety and quality improvement activities at least annually as part of the Annual Program Evaluation process. The GMEC will identify trends, areas of concern, and opportunities for institutional improvement and will document its oversight in meeting minutes.