Barriers	The largest barrier we encountered was time. Although 18 months seems like a long time, the months pass quickly. We worked to overcome the time challenge by staying organized and setting milestones for our program development.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Put together a strong, diverse team. Our team of experts from interprofessional areas within our system helped drive the success of our program development. This same group will ensure that our pilot program is successful.

Christiana Care Health System, Newark-Wilmington, DE

Developing a Resident Quality & Safety Council: Integrating Reporting and Improvement Science into Daily Work

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Background: Christiana Care, a major teaching hospital, provides the clinical learning environment for more than 270 residents/fellows in 13 residency programs. Our vision is that all residents will demonstrate that patient safety is a part of their profession. However, we found that although many residents observe safety events, few personally report them (<1% of all events reported by electronic form). Further, when events are reported, they are communicated through various paths, making it difficult to capture trends and patterns. This reporting data, a safety attitude assessment, and feedback from an ACGME CLER visit formed the basis for our effort to increase resident engagement and participation in patient safety through the creation of a Resident Quality & Safety Council.

Methods: The Resident Quality & Safety Council consists of faculty-resident dyads for all of our residency programs that were nominated by chairs and program directors. The council serves as a vehicle for enhancing communication between hospital committees and clinical departments and provides a forum for teaching safety concepts, discussing/disseminating specific system efforts, developing new initiatives, collaborating across departments, participating in safety activities, reviewing data, and providing feedback and solutions for system-level concerns. The council meets monthly for 1.5 hours with the assignment of between-session activities. Each session typically includes didactics, discussion of events/event reporting, reports of dyad-driven quality and safety activities/findings, and advice or consultation on system-level initiatives. The council reports activities to the system's GMEC and Safety Committee. Key measures of effectiveness included reporting climate data, resident participation in committees/councils, and percent change in self-reported attitudes about patient safety.

Results: In the quarter when the AIAMC NI IV project began (October 1, 2013–December 13, 2013), we had 56 resident-submitted Safety First Learning Reports (SFLRs). In the first quarter of 2014, the number increased to 76 resident-submitted SFLRs. The number of resident-submitted SFLRs dipped to 59 in the second quarter of 2014, but rose to 71 and 82 in the third and fourth quarters of 2014, respectively. The GME log of resident participation in health system forums showed a 75% increase in the number of residents participating in root cause analyses (RCAs) and debriefs in June 2014–February 2015 compared to the June 2013–February 2014 time period. According to the risk management event reporting system, the number of resident-submitted events increased 167% from the first measure of January 2013–December 2013 to the second measure of January 2014–December 2014. Safety attitudes remained relatively the same.

Conclusions: During our study period, we were able to demonstrate more than a 2-fold increase in the total number of resident-submitted SFLRs. Faculty-resident dyad participation not only enabled effective dissemination of quality and safety initiatives within and between programs but also strengthened mentoring relationships.

FINAL WORK PLAN – Christiana Care Health System

Team Charter/Objectives	Our approach to teaching patient safety and quality for residents is that the principles of patient safety and team-based care will become embedded so deeply that residents instinctively follow these best practices. We want 100% of our residents to demonstrate that patient safety is a part of their job within the next 12 months.
Project Description	A newly created Resident Quality & Safety Council that consisted of faculty-resident dyads for all residency programs was evaluated according to the following key measures: adverse event reporting rates by residents and programs; level of participation by residents in RCAs, debriefs, case conferences, department- and system-level quality committees/projects; percent change in resident self-reported attitudes about patient safety; level of participation in the council by dyads; and number of resident-led safety improvement initiatives/activities.
Vision Statement	Our vision is to move from the current state to a future state in which patient safety is not considered extra but is considered a core aspect of a resident's purpose/duty; patient safety is not project driven and not a part of culture, but there is a culture of patient safety in daily work; and patient safety is not someone else's job, but patient safety efforts are coordinated throughout the system. We want to move away from the recognition that there are unsafe events but gross underreporting to a state in which events are recognized and reported and new safety practices and system designs emerge with obvious faculty role modeling. Finally, many great patient safety initiatives are taking place across the system but they are not coordinated and many do not involve physicians. In the future state, when asked, all residents will be able to confidently speak about patient safety and acknowledge how it aligns with Christiana Care's goals.
Success Factors	Enthusiasm to seek the Resident Quality & Safety Council's advice was unexpected, including specific requests from the CEO/COO to help problem solve excessive capacity issues.
Barriers	The culture within our residency programs, among our faculty, and within our institution needs to be aligned to create the highly reliable environment our patients and community deserve.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Providing protected time for participation in council meetings and organizational committee meetings was critical.

Wayne State University and Crittenton Hospital Medical Center, Rochester Hills, MI

Implementing an Institutional Objective Simulated Handoff Evaluation for Assessing Resident Handoff Skill

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Background: Formal education about delivering effective handoffs is a known need for residency programs, and using a standardized process saves time and permits collaboration among programs. To address this need, Wayne State University GME created an institutional intervention on transition-of-care education. After the implementation of the institutional policy, transition-of-care task force members identified a need for monitoring resident handoff quality. For 2012-2013, the task force voted to replicate a 2010 study by Farnan et al by requiring residents to complete an objective simulated handoff evaluation (OSHE).

Methods: The task force developed a standardized template to be used by all programs for written handoffs. Each program designed a case and event that junior residents would hand off to senior residents. A total of 82 residents completed the