power. No improvement was seen in survival to discharge, although the rates in both groups are in the top decile of national hospitals and may reflect the ceiling for adult resuscitation mortality outcomes. The statistically significant increase in post-code withdrawal of life-sustaining care may reflect increased resident comfort in discussing end-of-life issues with patients' family members. Potential weaknesses of the study include insufficient power, lack of measured resuscitation-centered endpoints, no simulation training of ancillary staff, and observational bias.

FINAL WORK PLAN – Baylor University Medical Center

Team Charter/Objectives	Incorporating simulation training and mechanical and cognitive practices into the code blue educational training of internal medicine residents is essential to ensure ongoing cognitive analysis of resuscitative events and muscle memory of skills required in resuscitation. We hypothesized that these simulation efforts and interactive educational sessions would give trainees the confidence and experience to better analyze and manage resuscitation events and thereby increase the post-code survival-to-discharge metric at Baylor University Medical Center.
Project Description	Monthly simulation and educational sessions were conducted with the internal medicine resident code blue teams using a high-fidelity simulation mannequin. Rapid response team nurses, respiratory therapists, other ancillary staff, and physician faculty participated with the residents by performing ongoing real-time assessments and providing support and education in resuscitative techniques including intubation, rhythm recognition, identification of underlying causes of cardiorespiratory arrest, defibrillation, cardioversion, and pharmaceutical intervention. Trainees were required to obtain and maintain basic and advanced life support certification throughout their training. The objectives of the simulation sessions included timely delegation of roles, effective communication, familiarization with code supplies, recognition of rhythm abnormalities and underlying causes of cardiorespiratory arrest, proper use of equipment, and administration of treatment.
Vision Statement	Simulation training for code situations will (1) enhance patient safety by increasing post-code survival-to-discharge statistics compared with historical and national data, (2) increase resident resuscitation teams' comfort and confidence levels in various scenarios, (3) foster interdisciplinary teamwork and communication, and (4) provide an innovative model for other training programs.
Success Factors	The most successful components of our work were the comfort levels of residents to lead codes and patients' improved post-code survival. We were inspired by the cooperation and participation of multidisciplinary teams.
Barriers	The largest barrier we encountered was scheduling mock codes in the ICU and on floors in a busy hospital. To overcome this problem, we worked with room control to find empty rooms and with clinical managers and nursing leadership to allow the mock codes.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Write the code scenarios before the project begins. Training multidisciplinary teams rather than just the residents is important.

Baystate Medical Center, Springfield, MA

Resident Engagement in Quality Through a Resident Quality Council

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Background: House staff officers play a key role in patient care at academic medical centers and have unique insights into problems within a hospital, especially those that have the biggest impact on their daily work. However, resident input may not always be included in policy changes, and as a result, residents may not be engaged in adopting these

changes. To engage house officers in quality initiatives, we developed an interprofessional, interdisciplinary Resident Quality Council of 16 house staff officers representing 10 residencies and 3 fellowships. Resident Quality Council members identified a persistent problem with quickly and efficiently identifying the right person to contact for a consult. The Resident Quality Council's inaugural project was to develop a simple, standardized method for obtaining a consultation across specialties.

Methods: The process for obtaining a consultation was separated into parts, and key stakeholders in the pathway were identified. Each Resident Quality Council representative convened with his or her program and outlined the steps to obtain a consultant. The council selected a best practice. The group was then subdivided to investigate specific aspects of the problem. Group 1 contacted stakeholders in the consultation pathway, including residents, unit clerks and secretaries, and hospital operators, to identify their methods of contacting a consulting service. Group 2 developed possible outcome measurement tools and survey options to evaluate the changes implemented.

Results: The interdisciplinary group represented almost all specialties/subspecialties at our institution. We identified an opportunity for improvement that crossed multiple disciplines and affected patients on a daily basis but was not on the institution's radar. A new consult order was developed for internal medicine and Ob/Gyn.

Conclusions: The Resident Quality Council functioned well, and data gathering worked well because of the broad representation and the fact that residents work at the front lines of patient care. Working with the Department of Healthcare Quality (DHQ) in the future will help to align the goals of the hospital system with the projects chosen by the Resident Quality Council. Providing protected time and system resources for residents to engage in meaningful improvement projects will benefit everyone.

FINAL WORK PLAN – Baystate Medical Center

Team Charter/Objectives	The goals of this project were to engage residents in identifying interdisciplinary quality improvement projects; to use the Resident Quality Council to gather data, identify barriers, limitations, and opportunities in quality improvement initiatives; and identify one initiative that would have wide impact.
Project Description	Baystate Medical Center has a known challenge with correctly identifying the physician/provider to call when obtaining a consult, following up on a consult after it has been done, and having the consultant contact the care team—especially on nights and weekends when the original consulting physician is not covering. The Resident Quality Council project steps were to assess the extent of the problem, put a solution in place, and measure its effectiveness. Resident representatives identified key stakeholders and processes, selected a best practice, and developed outcome measurement tools and survey options.
Vision Statement	By March 2015, we will have piloted solutions and gathered data on the success or lack thereof for determining whom to communicate with regarding in-hospital consults. We will ideally have a new system in place that works across all specialties.
Success Factors	The most successful component of our work was working with the Resident Quality Council as a group. They were very effective at giving input and gathering information. We were able to identify a best practice and create a pilot for the best practice method.
Barriers	The largest barrier we encountered was scarce resources. For the residents, lack of time was a roadblock. We also did not have funding to help institute the pilot. We had identified an issue that was not on the hospital radar at all and were not working with the DHQ at the time. We worked to overcome these issues by keeping the pilot small and doing much of the work ourselves. The contact we had in information technology left Baystate Health, and we lost our ability to collect follow-up data.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	The Resident Quality Council needs to align goals with the health system goals and work directly with the DHQ. Projects must be doable within a year's time frame because members of the council rotate off or graduate and new members have difficulty picking up where the others left off.