Carolinas HealthCare System, Charlotte, NC

Certification Program in Patient Safety: Planning and Curriculum Design

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Background: The current and increasingly complex healthcare environment calls for greater attention to the achievement of quality, safe patient care. The best patient outcomes are a result of healthcare team members working collaboratively to make quality and safety a top priority. To help build a culture of safety and educate resident physicians, nurses, and advanced practitioners as engaged agents of change, we designed a 9-month interprofessional curriculum integrated within existing training programs.

Methods: The Carolinas HealthCare System (CHS) Certificate Program in Patient Safety was developed over 18 months. An invitation to join the program was provided to all CHS trainees in GME, nursing, and advanced clinical practice, as well as nursing teammates interested in career advancement in patient safety. Completion requirements included an average of 10 hours per month dedicated to the program, completion of relevant WHO patient safety modules, facilitation of small group teaching sessions, active participation in an interprofessional patient safety training triad patient safety team, and completion of a patient safety improvement plan modeled after an AHRQ case.

Results: Eight participants were recruited for the pilot program: 3 residents (Ob/Gyn, pediatrics, and neurosurgery), 2 nursing students, 2 nurses (a simulation center specialist and a patient safety educator), and an advanced care practitioner (trauma/surgical critical care). Because the program launched in March 2015 as a pilot, results will not be available until late 2015.

Conclusions: We have been inspired by the diversity of the group, the energy of these learners, and their excitement toward the program and becoming experts in patient safety.

FINAL WORK PLAN – Carolinas HealthCare System

Team Charter/Objectives	The Certificate Program in Patient Safety will build a culture of safety by integrating proven strategies into the education and training of new doctors, nurses, and advanced practitioners during their formal education programs. The program will educate and prepare the next generation of quality improvement innovators and patient safety leaders.
Project Description	Trainees were invited to apply to participate in the 9-month program. Minimum criteria to participate included being a trainee in good standing in a CHS medical or health sciences program; successful completion of 1 full year of postgraduate training; letter of recommendation from his/her program director; strong desire to gain further knowledge and experience in patient safety; and strong interpersonal and teaching skills**.** Completion requirements included an average of 10 hours per month dedicated to the program; completion of the WHO patient safety curriculum and the orientation to the program (virtual and live); facilitation of small group teaching sessions; active participation in patient safety teams; and completion of a patient safety improvement project.
Vision Statement	The Certificate Program in Patient Safety will build a culture of safety by integrating proven strategies into the education and training of new physicians, nurses, and advanced practitioners during their respective formal educational programs. Successful completion of the project will include excellent inaugural resident cohort satisfaction scores, increased engagement of CHS trainees in patient safety, improvement in CLER results in a patient safety focus area, enhanced interprofessional perceptions of residents, and improved patient safety metrics (relative to the focus area).
Success Factors	The most successful component of our work was recruitment of the 8 participants in the pilot program. We were inspired by the energy of these learners, the diversity of the group, and their excitement toward the program and becoming experts in patient safety.

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.