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

L Dillon; T Markova; J Coticchia

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

OSHE for a 91% participation rate. Faculty champions hosted a didactic session on transitions of care, secured resident availability, scored the written handoff, and provided resident feedback. Senior residents scored the verbal handoff and gave feedback.

Results: Survey results indicated resident confidence in picking up a new service significantly increased (t=2.12, [63], $P<0.05$.), along with improved ability to make contingency plans (t=2.00, [63], $P<0.06$), to perform a read-back (t=2.08, [63], $P<0.05$), and to know when to perform a read-back (t=2.78, [63], $P<0.01$). Written template scores varied by program.

Conclusions: Institutional educational interventions accomplish several objectives simultaneously. Such interventions are a demonstration of GME engagement and permit policy monitoring that does not detract from the educational focus. The OSHE is a simple but effective tool for sampling how faculty and residents deliver handoffs and provides an ongoing opportunity to refine handoff education.

FINAL WORK PLAN – Wayne State University and Crittenton Hospital Medical Center

Team Charter/Objectives	The goal of this project was to standardize resident-to-resident handoffs across all aspects of patient transfer within the hospital, services, outpatient, and discharge.
Project Description	We identified that follow-up appointments are critical in reducing readmission for COPD and CHF, and these served as the topics for the template. We used the OSHE to evaluate resident-to-resident handoffs and make recommendations. We analyzed qualitative data to identify transition-of-care gaps for each aspect of care and to evaluate the fit/utility of the template.
Vision Statement	We were able to demonstrate that institutionwide transition-of-care educational interventions were possible and sustainable while accounting for specialty variability.
Success Factors	Faculty engagement from all programs through an institutional task force that provided a platform for OSHE implementation was a key to success. The OSHE has become an annual monitoring tool for program compliance with the institutional transition-of-care policy.
Barriers	Senior residents reported difficulty in giving feedback to a fellow resident. As a result, feedback expectations were added to the didactic component.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Collaborate with the simulation center early to establish a standardized procedure. Link OSHE performance to direct observation of handoffs. Track and compare resident performance over time. Shape cases over time to accommodate changing program needs.

Florida Hospital, Orlando, FL

Advancing Patient Safety Education Through a Systematic Mortality Learning Program

Victor Herrera, MD; Joseph Portoghese, MD

Background: A need to improve the teaching of patient safety in GME exists. Traditional formats such as lectures have not been effective in engaging residents in a patient safety culture. Case-based and experiential learning have demonstrated the capacity to advance skills and change behaviors.

Methods: We developed a structured curriculum employing case-based exercises and interactive delivery of content using the Florida Hospital Mortality Review Program as a framework. Residents assigned to plan a mortality and morbidity presentation participated in 2 phases of training under faculty supervision, with emphasis on patient safety education and learning of the IHI Global Trigger Tool for Measuring Adverse Events methodology as it relates to mortality reviews.