

Vision Statement	We will maintain a simple, yet effective quality improvement curriculum that is adaptable to all GME programs at Orlando Health and will help residents better facilitate quality improvement projects.
Success Factors	We were able to collaborate with all the GME program representatives to administer the questionnaire/survey to the residents. Now we have an idea of how much the residents are retaining from the developed curriculum. We were inspired by the level of retention (percentage) to find ways to ensure that resident education in quality improvement core concepts is more effective as well as sustainable.
Barriers	The largest barrier we encountered was resistance and lack of eagerness to participate. Time management was another issue, principally related to the busy schedules and responsibilities of the residents. We worked to overcome these challenges by reaching out to chief residents and clinical coordinators of the residency programs so the task of collecting the data could be completed.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Have a realistic time frame to collect the data and maintain frequent communication with clinical coordinators and chief residents of the respective programs. Having a representative on the corporate level is helpful for fostering excitement about the project.

OSF Saint Francis Medical Center and University of Illinois College of Medicine, Peoria, IL

Rates of Medical Errors and Adverse Events in a Medical ICU Following Implementation of a Standardized Computerized Handoff System

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Background: The current process in the adult ICU does not include a controlled environment or a consistent process for delivering handoffs or standardized time. This project evaluated the effectiveness of and staff satisfaction with resident handoffs at baseline and then performed a reevaluation after the I-PASS handoff system was integrated with Epic in the OSF Saint Francis Medical Center (SFMC) adult ICU.

Methods: We provided a controlled and quiet environment for handoffs, an integrated handoff tool (I-PASS plus Epic), and a robust educational bundle with simulation/role playing, didactics, and small group work. There is a monthly rotation of residents in the adult ICU. We observed handoffs, completed the intervention education, and observed handoffs again (verbally and electronically). The intervention consisted of a 3-4 hour training seminar consisting of a standardized didactic component, sample videos of appropriate and inappropriate handoffs, and interactive simulation training on proper handoffs and event reporting, followed by a debriefing period. Staff and providers completed a daily nursing or resident survey for unreported events, good catches, and near misses. These survey responses were compared to the electronic event reporting system for transparency.

Results: We have data for discussion but lack the depth needed to show significance in the intervention month to month. No significant change in the depth of handoff was seen although we found more transparency of the handoff process in the adult ICU.

Conclusions: We brought awareness and increased communication about failure points in the process, and this project brought strong leadership commitment to the handoff. Adding *good catch* to the resident survey was a quick win so the focus was not negative. Standardizing the monthly calendar in advance in terms of timing of education and observations requires more work.

**FINAL WORK PLAN – OSF Saint Francis Medical Center and
University of Illinois College of Medicine**

Team Charter/Objectives	The objective of this project was to implement I-PASS in an adult ICU setting and to evaluate handoffs before and after an educational intervention. The project will increase our understanding of adverse events, near misses, and good catches in the adult ICU and standardize the handoff to create a concise product that will increase patient safety.
Project Description	After implementing the I-PASS handoff system in the adult ICU and providing an educational intervention, we will evaluate handoffs postintervention and compare them to handoffs prior to the intervention. We will report any resident handoff issues via Peminc (online reporting tool) and analyze the data on a monthly basis over a 6-month period.
Vision Statement	This project will allow us to see an improved resident handoff in a controlled environment (verbally and electronically) and will result in more reporting to our electronic event reporting system. The process will create a concise and standardized resident handoff tool using I-PASS to improve patient safety by enhancing communication and satisfaction among residents rotating through the adult ICU.
Success Factors	The most successful components of our work were increased event reporting and reduced handoff errors.
Barriers	The resident intervention was difficult because of clinical schedules. Timing of the verbal handoff was not always consistent. The daily nursing and resident survey was more labor intensive than we anticipated. Observations were assigned to a dedicated nonclinical team member to provide consistency but needed more around-the-clock vigilance to obtain a true picture. In addition, more work is needed to get communication and transparency of good catches and near misses to staff and residents.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	We underestimated the resources to execute this project. Make sure you have backups for all of the tasks needed.

**Our Lady of the Lake Regional Medical Center,
Baton Rouge, LA**

**Improving Resident Education of Patient Safety: A
Campuswide Initiative**

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Background: Residency programs at our institution were implementing patient safety curricula in a variety of ways but rarely communicated with one another. The objective of this project was to develop and implement a campuswide, standardized learning experience to enhance residents' knowledge of patient safety.

Methods: In phase 1, coinvestigators from 5 residency programs brainstormed a standardized learning experience. The working group determined that using text message reminders to facilitate patient safety discussions on hospital-based rounds would be a novel and accessible means of engaging faculty and residents. Participating faculty were provided with a training video that modeled how to incorporate patient safety discussions on rounds. Phase 2 was a pilot study that began in spring 2014. During a 2-month period, participating faculty received weekly text reminders to discuss patient safety on rounds. Residents on hospital-based rotations participated in the safety rounds initiative, and residents on alternative rotations served as a control group.