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 Peminic (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.

Results: We observed increases in resident perceptions of the culture of quality and patient safety at our institution as a result of our initiative, particularly in the communication and event reporting sections of the modified AHRQ survey (administered pre/post pilot). Ninety-five percent of faculty who completed the follow-up survey reported that they were continuing to incorporate patient safety discussions on rounds after the pilot phase.

Conclusions: We believe this standardized learning experience led to an increased sense of ownership of quality and patient safety on the part of our physician learners and teachers, as evidenced by significant movement in residents' perceptions and reporting activity. Additionally, our experience in NI IV brought faculty and residents out of departmental silos and engaged them to work with quality leaders at the hospital to improve patient safety outcomes. This collaborative momentum yielded an additional outcome: the creation of a quality and patient safety fellowship beginning in academic year 2015.

FINAL WORK PLAN – Our Lady of the Lake Regional Medical Center

Team Charter/Objectives	Our Lady of the Lake Regional Medical Center is the sponsoring institution for a pediatric program and recently became the primary clinical site for 4 Louisiana State University (LSU) residency programs and a major participating site for 13 additional LSU residency programs. There was variability in the quality improvement curriculum offered in each of the residency programs and limited resident integration in hospital quality improvement/patient safety initiatives. Our objective was to develop a standardized educational intervention focused on patient safety across the 4 residency programs.
Project Description	In phase 1, preintervention data were collected at baseline using the modified AHRQ survey. The project working group developed a weekly text reminder that was sent to faculty, asking them to incorporate patient safety discussions during rounds. In phase 2, faculty were required to respond that patient safety discussions had taken place. They were encouraged to share deidentified information about what types of discussions took place. In phase 3, postintervention data were collected using the modified AHRQ survey.
Vision Statement	The ultimate goal of this pilot project was to build a quality improvement initiative that would positively influence the culture of patient safety at the hospital and better integrate residents into the hospital's patient safety initiatives. A secondary goal was to publish a minimum of one peer-reviewed manuscript by March 2015.
Success Factors	Weekly text message reminders ensured that our faculty remained engaged and that patient safety discussions were relatively standardized. The most successful component of our work was engaging faculty and residents in patient safety discussions. Our ability to close the feedback loop on several key patient safety issues allowed us to reinforce reporting and increase physician communication of patient safety issues. We were inspired by our colleagues in NI IV. Hearing them discuss problems they had been facing within their hospitals enabled us to focus our project.
Barriers	The largest barrier we encountered was initially having faculty and residents buy in to having patient safety discussions on rounds. We overcame this barrier by offering faculty development to increase confidence in leading discussions and reinforce the importance of having these discussions. Also, we were able to close the feedback loop, so residents and faculty could see the impact of identifying patient safety issues. This significantly reinforced the importance of patient safety discussions and empowered faculty and residents.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Keep your project simple, focused, and structured. It is also important to incorporate outcome measures that allow you to track whether your intervention has had an impact on the variable you wished to change.