FINAL WORK PLAN – Scott & White Healthcare

Team Charter/Objectives	We observed a need to standardize the patient handover process throughout the hospital. We aimed to improve the sharing of information and involvement of house staff at the institutional level of the Patient Safety & Quality Council and to improve communication between house staff and senior administration of the institution.
Project Description	To assess the current state of handoffs and transitions of care, we conducted a survey of house staff. We developed a template and made it available in New Innovations, allowing programs/departments to build on the template. The project was an institutional priority, and all departments were expected to buy in to develop a standard process. Each department was allowed to add items as needed so foster ownership of the process rather than a feeling that it was coming from the top.
Vision Statement	We will develop a systemwide transitions-in-care protocol and allow individual departments to add information as needed to meet the departmental requirements.
Success Factors	The most successful component of our work was creating a systemwide transitions-in-care checklist. We were inspired by the work and energy the House Staff Quality Council had previously achieved. After the CLER visit, our program directors took the lead in developing workable solutions in the areas of transitions in care and supervision along with our House Staff Quality Council.
Barriers	The largest barrier we encountered was time. Our team members are nearly all clinicians, and organizing meetings was very challenging with their limited availability. We worked to overcome this challenge by communicating via email and adding the project as a GMEC agenda item when necessary.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Consider the availability of your members and get the house staff involved as early as possible.

Scottsdale Lincoln Health Network, Scottsdale, AZ

CAUTI Prevention Through Education, Continuum of Care, and Systemwide Buy-In

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Background: Catheter-associated urinary tract infection (CAUTI) rates were very high, especially in the Scottsdale Health Network Osborn campus ICU. With the aim to decrease CAUTIs, we collaborated with a systemwide CAUTI taskforce and created a resident quality champion position for GME.

Methods: We presented a multidisciplinary CME forum on CAUTI, implemented daily management plans to track catheter use, implemented a urine retention protocol, instituted ED education, and created EMR prompts requiring physicians to enter the reason for a urinary catheter when ordered and to ask physicians if a urinary catheter could be removed or to list the indication for continued use.

Results: The total number of CAUTIs at 3 campuses was reduced from 70 to 52 between 2012 and 2014, and the total number of Foley days was reduced from >16,000 to <13,000 between 2012 and 2014.

Conclusions: As a project team that focused on patient safety and decreasing mortality and morbidity, we were successful. Our hope to completely eliminate CAUTIs in our system was not met. However, many key initiatives will continue and

should lead to further reduction in CAUTIs in future years. A multidisciplinary, multifaceted approach with resident involvement is feasible and had a positive impact in our system. The resident quality champion position will continue, as will efforts to reduce CAUTIs.

FINAL WORK PLAN – Scottsdale Lincoln Health Network

Team Charter/Objectives	We aimed to create a project to engage residents in Scottsdale Healthcare (SHC) quality improvement efforts using the ZERO CAUTI Collaborative as a model with the long-term goal of reducing the SHC CAUTI rate to zero.
Project Description	The AIAMC IV team will collaborate with hospital quality leaders in a multidisciplinary, multifaceted fashion, with resident leadership. Elements include (1) collaborating with the SHC CAUTI taskforce (creating a CAUTI bundle, working on nursing-led efforts to reduce catheter use, and picking a high-risk unit for implementation; (2) preparing and presenting a CME multidisciplinary conference addressing CAUTI prevention; (3) implementing a resident teaching service initiative to record Foley use and indication on the patient census and in progress notes; (4) working with administration and the medical staff on physician efforts to reduce catheter use; (5) collaborating with the ED to reduce unnecessary urinary catheter insertions; (6) collaborating with surgical units to reduce intraoperative urinary catheter use and encourage removal in the recovery room when a catheter is no longer indicated; (7) collaborating with urology to create a protocol that addresses urine retention in the hospital.
Vision Statement	Residents will be actively involved in quality improvement efforts at SHC, and the institution will be well along the path to the quality goal of zero CAUTIs.
Success Factors	The most successful component of our work was the culture change in the ED and on the medical floors to significantly reduce urinary catheter use in our hospital. A conversation was started that helped reduce Foley days in our ICU by 30%. We were inspired by the teamwork witnessed—a true multidisciplinary and interprofessional effort of nursing, physician leadership, the quality improvement team, and the information technology team to help with EMR changes.
Barriers	The largest barrier we encountered was entrenched practices by both physicians and nurses in the ICU setting; it proved hard to change the culture in that arena. We worked to overcome this challenge by ongoing education and instituting a management system with daily huddles and tracking of patients who had Foley catheters.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	Teamwork and ongoing communication and education are critical.

TriHealth, Cincinnati, OH

Improving Patient Safety Event Reporting Among Residents and Teaching Faculty

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Background: A June 2012 site visit report from the ACGME CLER revealed residents' and physicians' lack of awareness and understanding of the hospital's system for reporting patient safety concerns in 3 areas: (1) what constitutes a reportable patient safety event, (2) who responsible for reporting, and (3) the current reporting system.