

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.

Methods: We conducted a quality improvement study consisting of an educational program (intervention) focusing on the importance of event reporting and a pre/post educational survey to measure attitudes, knowledge, and self-reported behaviors. Following the implementation of a new patient safety event reporting system, we compared the reported events with baseline data to determine improvement in reporting. Subjects included residents and teaching faculty from the internal medicine/family medicine, general surgery, Ob/Gyn-urogynecology, and vascular surgery GME programs.

Results: Among 105 residents, the response rate was 56%-92% for the preintervention survey and 68%-100% for the postintervention survey. Among 78 teaching faculty, the response rate was 43%-67% for the preintervention survey and 33%-92% for the postintervention survey. The majority of respondents agreed that as a healthcare provider, they will be responsible for a medical error at some point, and to improve patient safety, serious events should be reported to hospital administration. Of all respondents, 62% did not have medical error report training in their medical schools; 71% had never used the online error event reporting system in our healthcare organization; 33% indicated that they did not receive education/training on how to disclose medical errors to hospital administration, and 76% indicated that they will likely report medical errors. Most important, the number of reported patient safety events increased. The preintervention average was 1.5 events, while the postintervention average was 4.6 events.

Conclusions: Immediately after the intervention, we achieved an approximately 5-fold increase in the number of reported events by residents and teaching faculty. The educational intervention improved knowledge of which incidents or errors to report. Also, after the intervention, in 3 of the 4 residency programs, more residents responded that they would report an error even if their colleagues or attending physicians disagreed.

FINAL WORK PLAN – TriHealth

Team Charter/Objectives	By March 2015, all of our residents and teaching faculty will know and recognize the list of serious reportable events and will demonstrate a 4-fold increase in the use of the event reporting system within 48 hours from occurrence of the event.
Project Description	The project will be composed of the following elements: (1) residents and faculty will become knowledgeable of serious reportable events for their specialty; (2) we will establish the desired culture and behavior and model it; (3) we will assist with the successful implementation of the new event reporting system; and (4) we will develop a process map of what happens with a reported event and ensure all residents understand the process.
Vision Statement	A sustainable program of culture of safety will be fully integrated into all GME programs. We will see an increase in self-reporting faculty and staff who will lead these efforts for their respective specialties, and technology will be effectively leveraged in these efforts.
Success Factors	The most successful component of our work was having representatives from each residency program involved, including both residents and faculty. We received excellent financial support from our administration. We were inspired by our CLER report. The feedback and guidance from our ACGME site visitors was constructive and specific.
Barriers	The largest barrier we encountered was the delay in implementation of our new event reporting system. We worked to overcome this challenge by focusing on resident and faculty education on serious reportable events. We believe this focus improved the effectiveness of our intervention once the event reporting system was ready for go-live.
Lessons Learned What is the single most important piece of advice for another team embarking on a similar initiative?	GME leadership needs to involve program directors in the process early. It was difficult to get buy-in and interest from all the programs early in the process.