

WATCHER INITIATIVE DECREASES UNSAFE TRANSFERS TO A HIGHER LEVEL OF CARE (QI Abstract) *Melanie M. Smith DO, Maryanne M. Chumpia MD, Lindsey*

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Background Unrecognized clinical deterioration is a serious safety issue, and inability of care teams to promptly identify decompensating patients often leads to preventable undesirable outcomes. In an effort to reduce the number of poor clinical outcomes, we referenced an existing model at Cincinnati Children's Hospital where huddles were used to identify "watchers" and prevent "unrecognized situation awareness failure events" (UNSAFE). We modified their system to fit our hospital's floor-based inpatient setting. UNSAFE transfers include patients who required intubation, vasopressors, or ≥ 3 fluid boluses either before or within one hour after transfer to a higher level of care. **Aim Statement** Our goal was to decrease the number of UNSAFE transfers from the targeted inpatient floor(s) to an ICU setting by 50% over a 6-month period. **Interventions** In May

2015, we asked residents and nurses to identify "watchers" based on defined criteria. This was reported in a daily safety brief. In July, we piloted twice daily huddles on an inpatient floor and have been implementing them on the remaining floors since that time. These huddles include a nursing patient care coordinator, supervising resident(s), and respiratory therapist. The huddles occur twice daily to communicate a plan for intervention and expected outcome within a designated time frame. This information is then disseminated to the bedside nurse and intern, who follow up on the outcome. **Measures** We evaluated the number of UNSAFE transfers, as well as deaths on the floor, compared to the total number of transfers to an ICU setting. **Results** Prior to starting the daily safety brief in May, the percentage of UNSAFE transfers to a higher level of care was 14% over the previous 16 months. Our first intervention resulted in a 61% decrease in UNSAFE transfers. After our second intervention, the percentage of UNSAFE transfers was 3.7%, which is a total reduction of 74% from baseline. **Conclusions and Next Steps** By ensuring that all members of the care team are aware of an at-risk patient's clinical status, watcher huddles incorporated into the daily inpatient routine can significantly decrease the number of UNSAFE transfers to a higher level of care.