Improving Safe Handoffs & Transitions ED→ R2 + P3CD: A Response to the AHRQ Hospital Patient Safety Culture Survey

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Plan

Problem/Impact Statement:

Background: Handoffs and Transitions was the lowest scoring domain in the 2016-17 AHRQ Hospital Survey on Patient Safety Culture falling below the national average (48%) at our health system, in all 8 of our hospitals. As a result, each hospital implemented an initiative to improve Handoffs. There are 4 questions included in the Handoffs and Transitions domain of the survey. The question 'Things fall between the cracks when transferring patients between units' was the lowest scoring at Maine Medical Center (MMC), a 637-bed, academic, Magnet hospital. In September 2017, The Joint Commission issued a Sentinel Event Alert indicating handoffs should include at minimum a structured approach with a verbal handoff, providing further support to the area of focus.

Problem statement: Upon further analysis, it was identified that there was no standard process for verbal handoff of patient care information when transferring patients between ED and inpatient units at MMC.

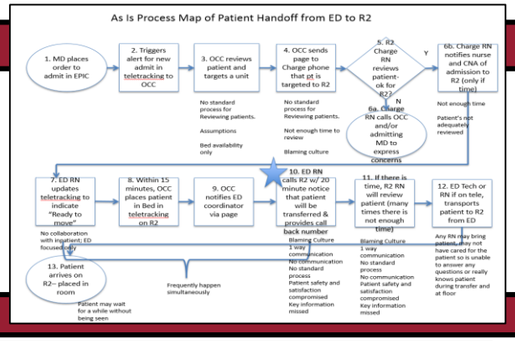
Aim and Goals:

1.Outcome: We aim to improve the Handoffs and Transitions Domain and the question: 'Things fall between the cracks when transferring patients between units' of the AHRQ Patient Safety Culture Survey by 5% from the 2017 baseline by December 2018 in ED, R2 and P3CD.

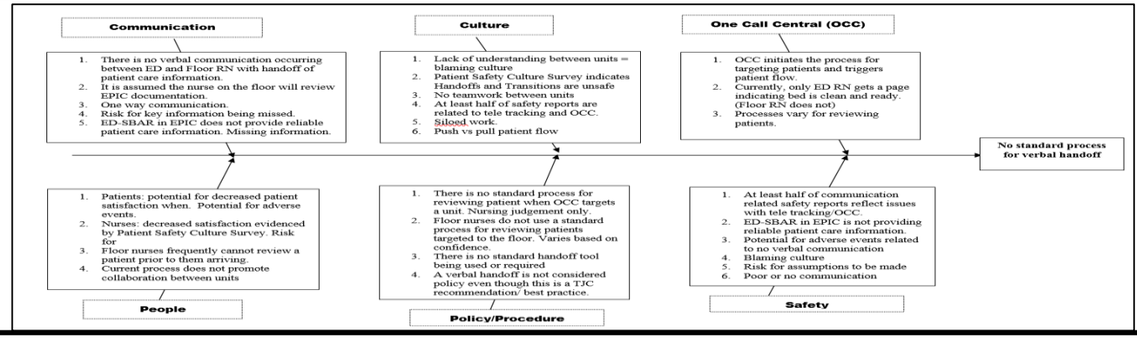
2. Process: Establish a process for incorporating a verbal handoff 100% of the time for all patients who are admitted from the ED to R2 + P3CD using an evidence based mnemonic tool to structure the content by March 5th, 2018.

Current State:

We noted several steps in the process to be out of scope. The blue star highlights the steps in the current state that we could improve, including implementing the standard verbal handoff process. As a result, a **Balancing Measure** for this project included monitoring ED to floor times for patient flow.



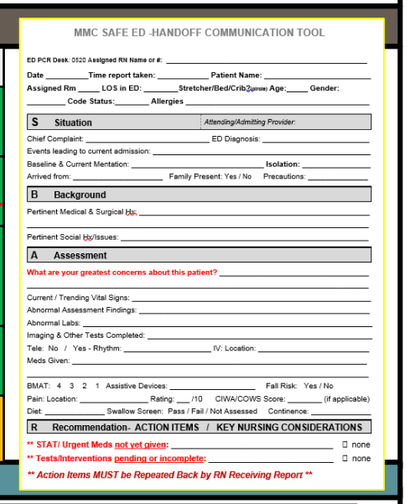
Root Cause Analysis:



Do

Countermeasures

Action:	Due Date	Status
Map current state (Process) Map ideal state/Ideal State Revised (Process)	Nov 15th Jan 10th & Jan 31st	Complete Complete
Create template for safe handoff with relevant content & educate on process and handoff tool	Feb 15th- Mar 3rd	Complete
Implement 1st test of change: 100% of the time patients admitted from ED to R2 + P3CD will have a verbal handoff utilizing handoff tool	Mar 5th	Complete
Administer survey to R2, P3CD, and ED staff assessing perceptions of handoff process	May 5th	Complete
Spread to other units: Educate staff nurses	July- Oct	In Progress


MMC SAFE ED -HANDOFF COMMUNICATION TOOL

ED PCR Desk: 0520 Assigned RN Name or #: _____

Date _____Time report taken: _____ Patient Name: _____

Assigned Rm _____ LOS in ED: _____Stretcher/Bed/Crib(Circle) Age:_____ Gender: _____ Code Status:_____ Allergies _____

S Situation *Attending/Admitting Provider:*

Chief Complaint: _____ ED Diagnosis: _____

Events leading to current admission: _____

Baseline & Current Mentation: _____ Isolation: _____

Arrived from: _____ Family Present: Yes / No Precautions: _____

B Background

Pertinent Medical & Surgical hx: _____

Pertinent Social hx/Issues: _____

A Assessment

What are your greatest concerns about this patient? _____

Current / Trending Vital Signs: _____

Abnormal Assessment Findings: _____

Abnormal Labs: _____

Imaging & Other Tests Completed: _____

Tele: No / Yes - Rhythm: _____ IV: Location: _____

Meds Given: _____

BMAT: 4 3 2 1 Assistive Devices: _____ Fall Risk: Yes / No

Pain: Location: _____ Rating: ___/10 CIWA/COWS Score: _____ (if applicable)

Diet: _____ Swallow Screen: Pass / Fail / Not Assessed Continence: _____

R Recommendation- ACTION ITEMS / KEY NURSING CONSIDERATIONS

** STAT/ Urgent Meds not yet given: _____ ☐ none

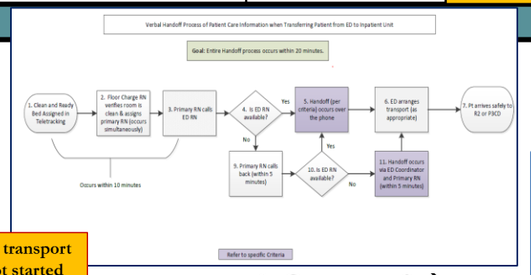
** Tests/Interventions pending or incomplete: _____ ☐ none

** Action Items MUST be Repeated Back by RN Receiving Report **

Study

Outcomes

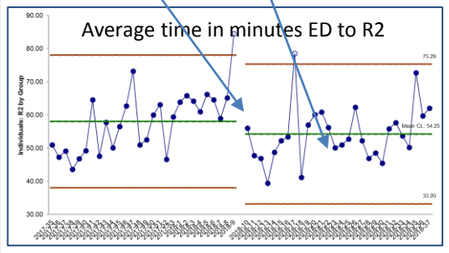
1. NEW "Pull" Process →



2. Balancing Measure:

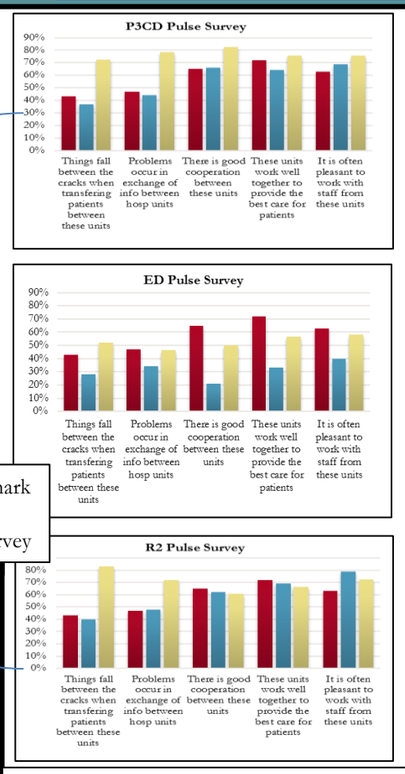
Verbal Handoff Started

ED transport Pilot started



3. Outcomes* →

We noted at least a 5% improvement in the handoffs questions from the baseline on all units. 103 total responses.



Red= AHRQ Benchmark
Blue= 2017 Baseline
Gold= 2018 Pulse Survey

*Questions were adapted from AHRQ survey to assess the new process

Act

Lessons Learned & Next Steps

1.Improving handoffs is **culture change,** which takes time. Providing time for consensus building & setting guiding principles for the team was essential.

2. **Sustainability:** Next steps have included expanding to all patients admitted from ED to any inpatient unit. Expanding the same verbal handoff process to PACU admissions.

3. Next steps also include optimizing handoff tools in the EHR.

4. Working with others in our health system allows for sharing of ideas and tools. The tool used originated from one of the other hospitals, then edited.