


NCQC Patient Safety Organization

Fall 2015 Safe Tables: Handoff Communication

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Safe Table Objectives

- Support our commitment to reduce harm to patients
- Develop a community of learning by sharing our stories
- Promote discussion about mistakes to gain insight into improvements that are needed within our organizations
- Share best practices
- Network and communicate

Today's Agenda

- 10:00 - 10:15 a.m. Welcome & Introduction
- 10:15 - 10:45 a.m. Handoff Background
- 10:45 - 12:15 p.m. Sharing & Safe Table Discussion
- 12:15 - 12:30 p.m. Quick Break
- 12:30 -1:30 p.m. Lunch & Safe Table Wrap Up

Regulatory Requirements

The Joint Commission National Patient Safety Goals (NPSG 2E) requires:

1. Standardized approach
2. The opportunity for questions
3. Accurate, up to date information

The Accreditation Council for Graduate Medical Education requires:

- residency programs maintain formal educational programs in handoffs and care transitions

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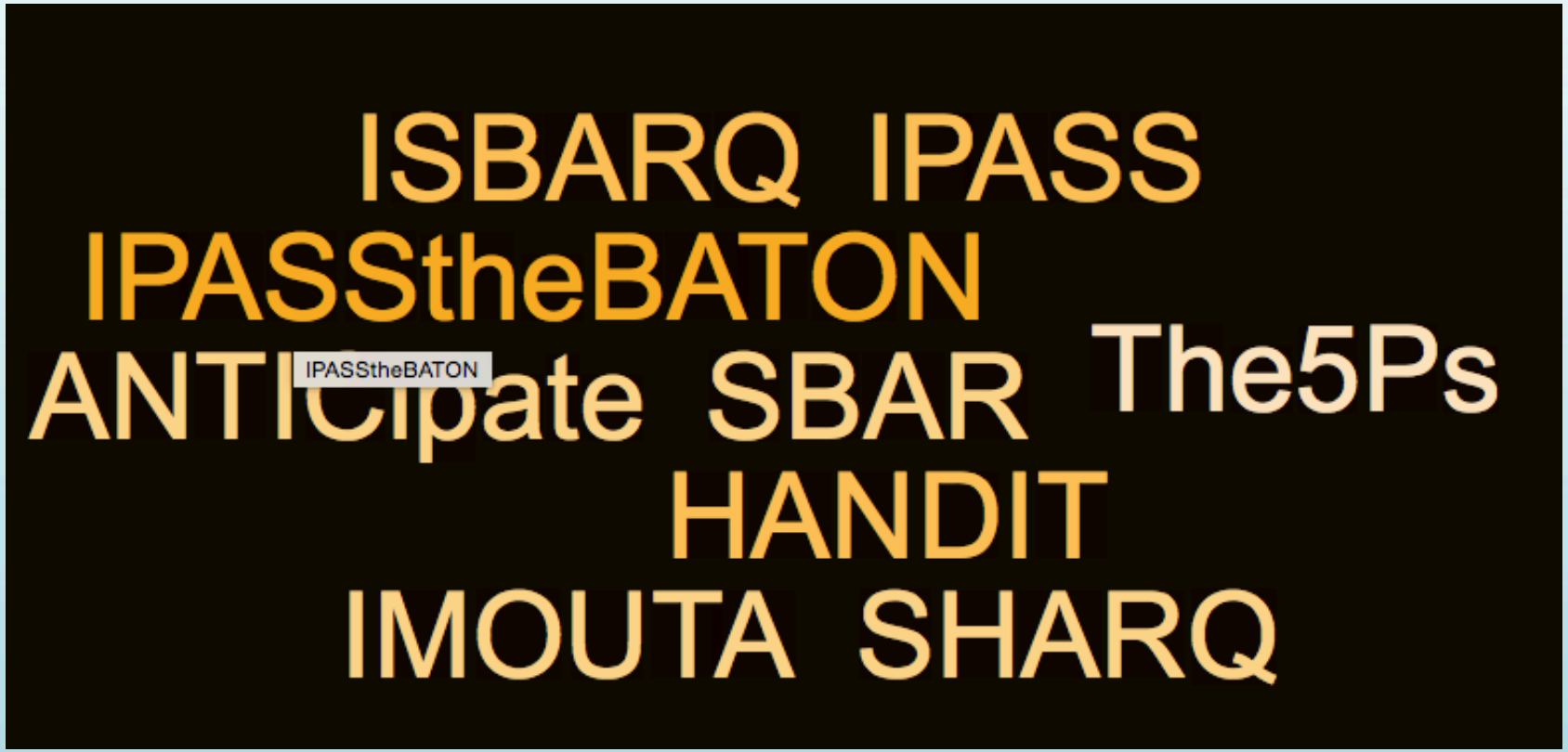
What Communication Tool(s) do you use in your organization during Handoff?



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Handoff Communication: A Look at Reality and Perception

Reality

What is happening with handoff communication?

Perception

How do we perceive the effectiveness of our handoff communication?

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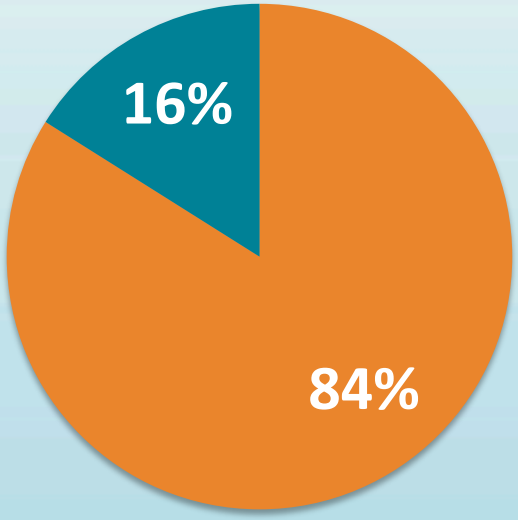
Reality of Handoff Communication: Incident vs. Near Miss

Rate of Incident vs Near Miss in Handoff-Related Event Search



- Incident: A patient safety event that reached the patient, whether or not the patient was harmed.
- Near Miss: A patient safety event that did not reach the patient.

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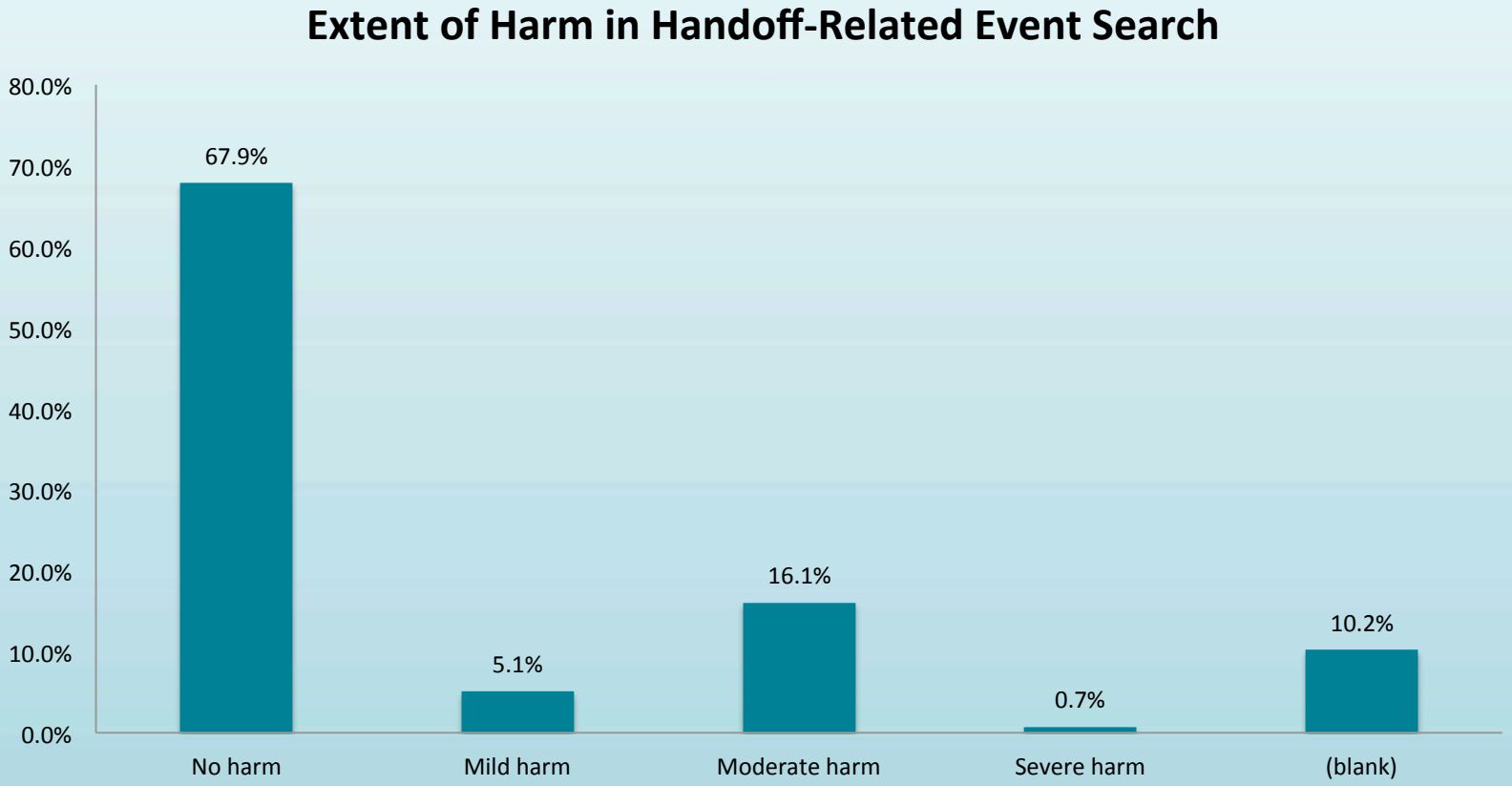
Reality of Handoff Communication: Extent of Harm



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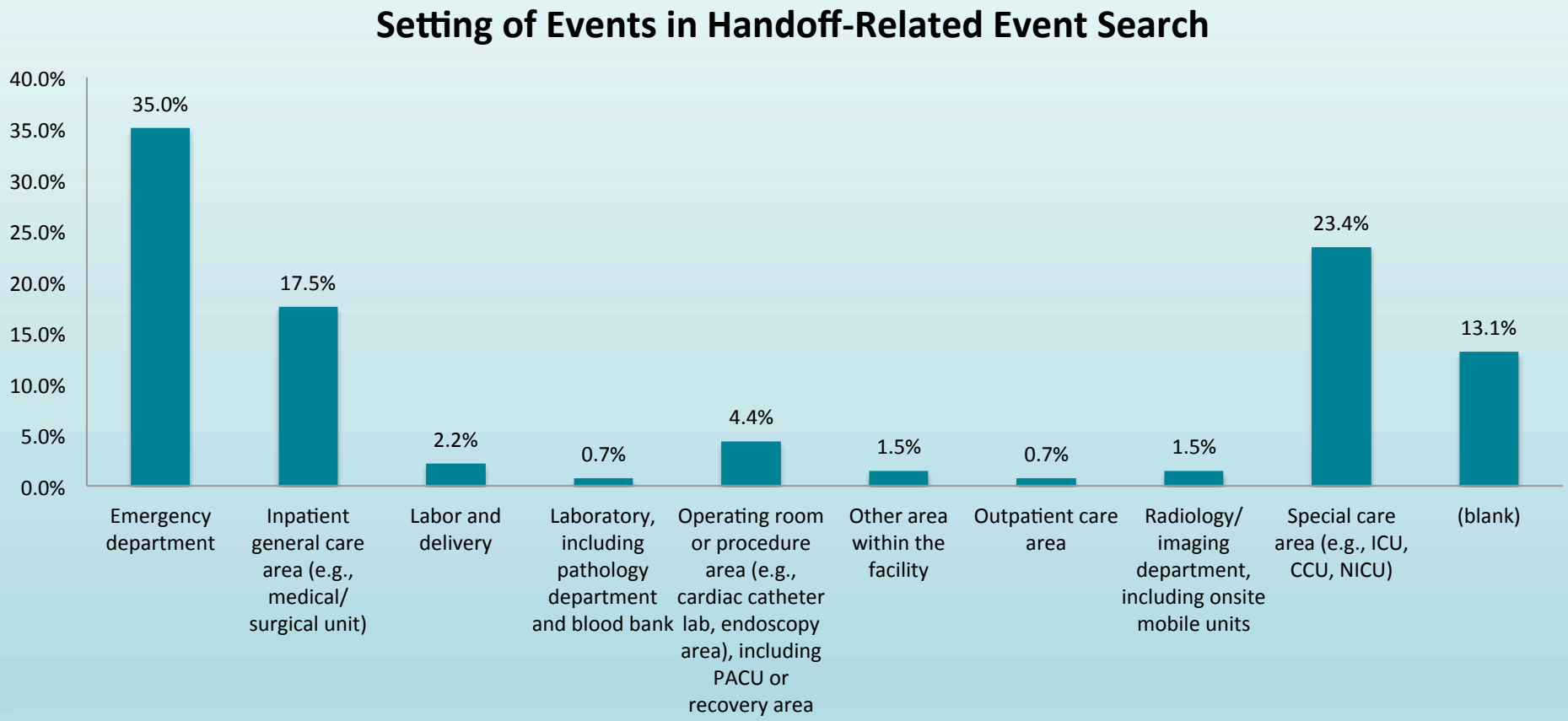
Reality of Handoff Communication: Setting of Events



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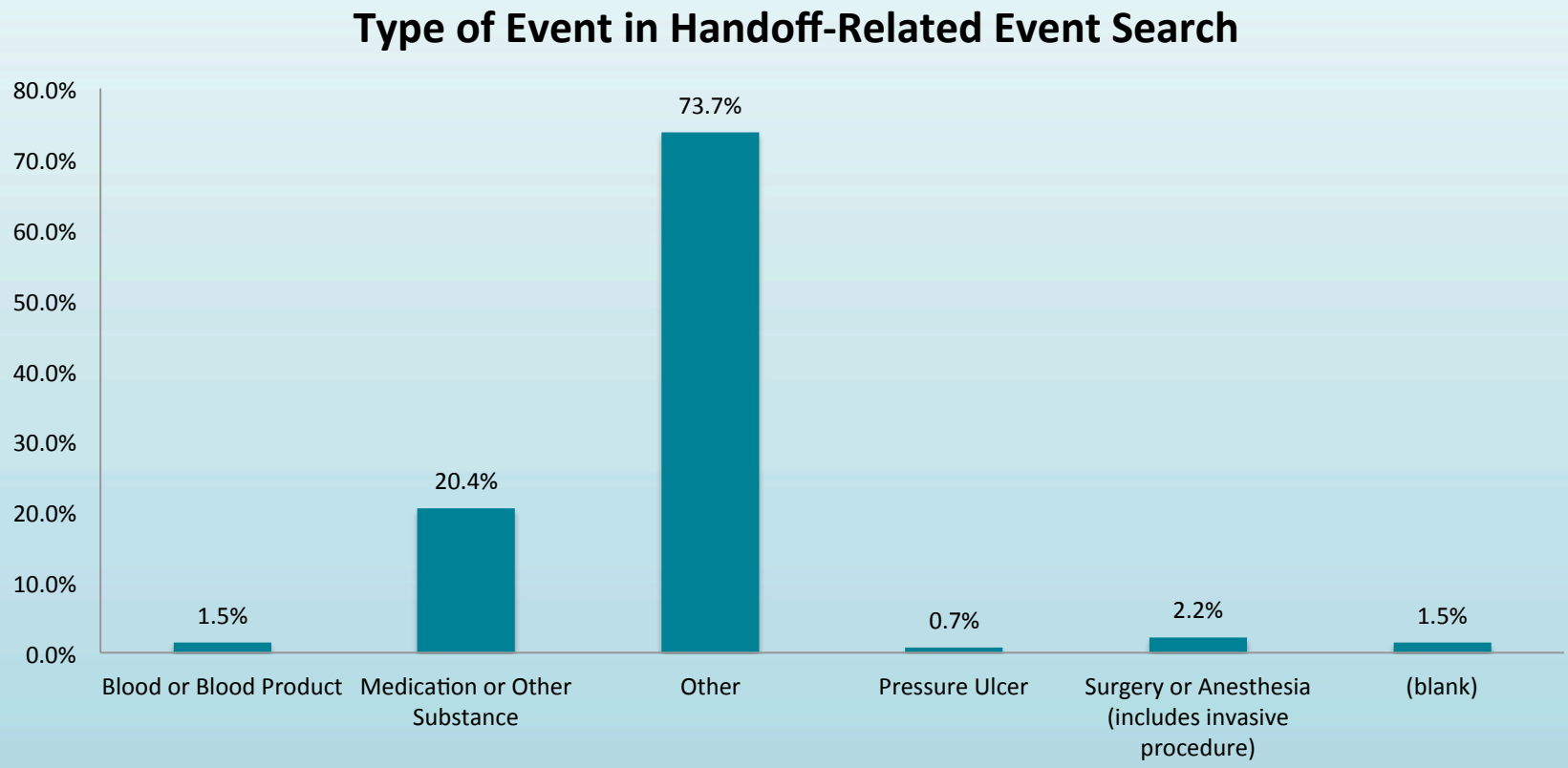
Reality of Handoff Communication: Type of Events



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Perception of Handoff Communication: Hospital Survey on Patient Safety Culture

- HSOPS was released by Agency for Healthcare Research and Quality (AHRQ) in 2004 for national use
- Measures hospital staff perspective on patient safety
- 42 questions plus demographic section in national survey
- 12 dimensions/composites used to summarize results nationally

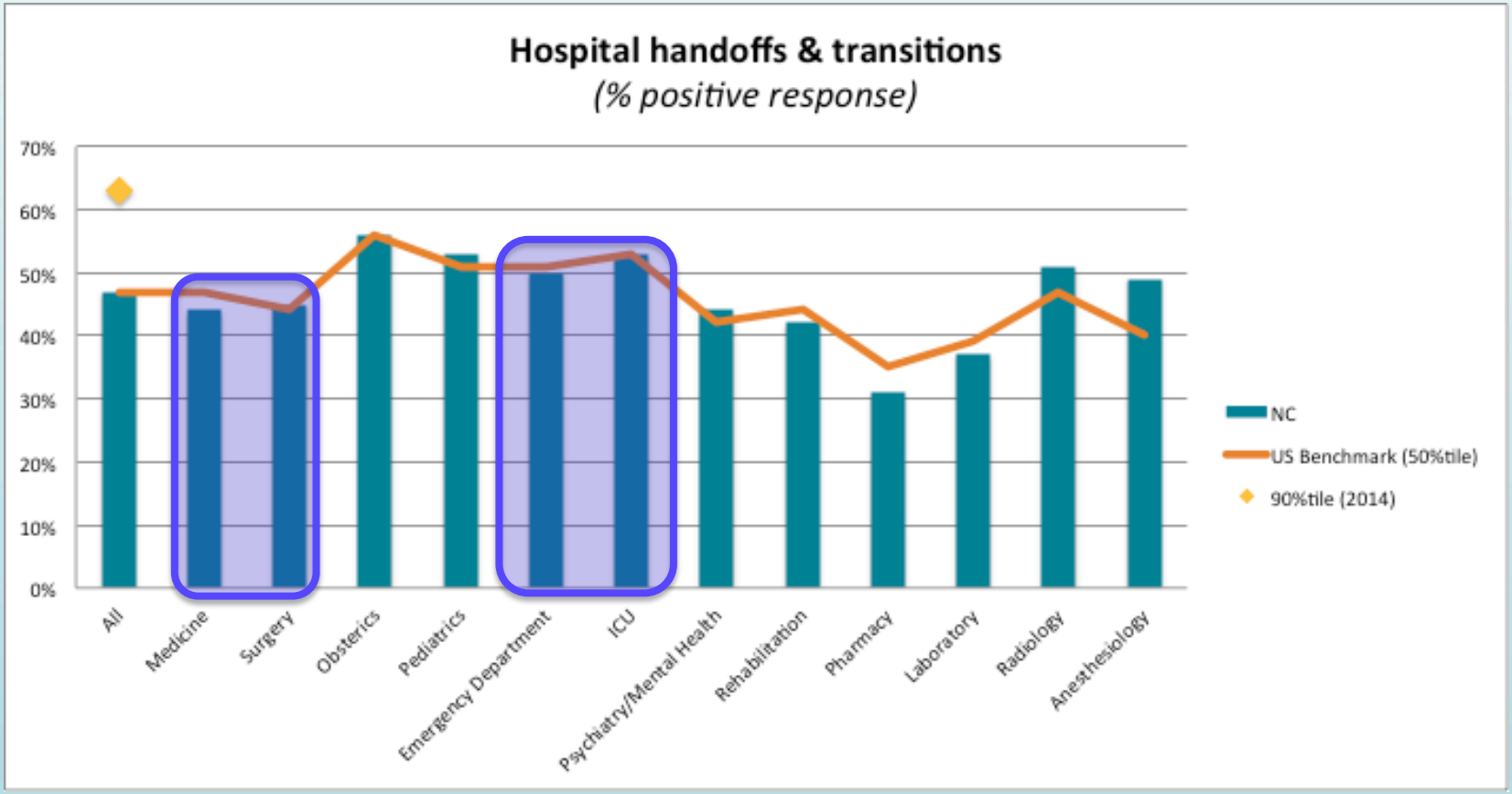
Perception of Handoff Communication: Interpreting HSOPS

Type	Example Question (s)	Positive Responses
Positively Worded Question	"Patient Safety is never sacrificed to get more work done." "Our procedures and systems are good at preventing errors from happening."	• Strongly Agree • Agree • Always • Most of the Time
Reverse Worded Question	"It is just by chance that more serious mistakes don't happen around here." "We have patient safety problems in this unit."	• Strongly Disagree • Disagree • Never • Rarely

HSOPS Survey: Hospital Handoffs & Transitions Dimension

- Things "fall between the cracks" when transferring patients from one unit to another.
- Problems often occur in the exchange of information across hospital units.
- Important patient care information is often lost during shift changes.
- Shift changes are problematic for patients in this hospital.

HSOPS Survey: Hospital Handoffs & Transitions - Overall



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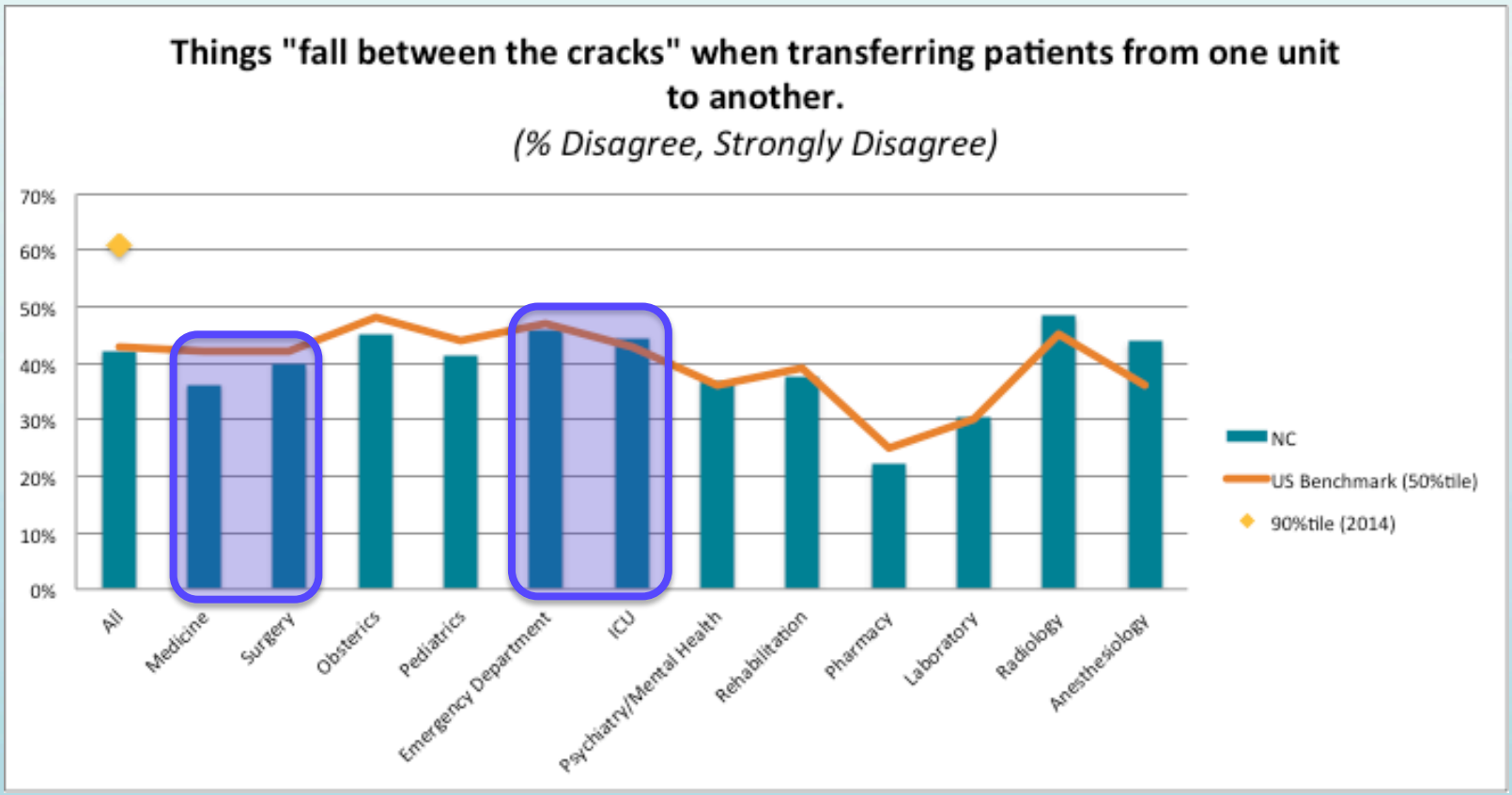
HSOPS Survey: Things “fall between the cracks”…



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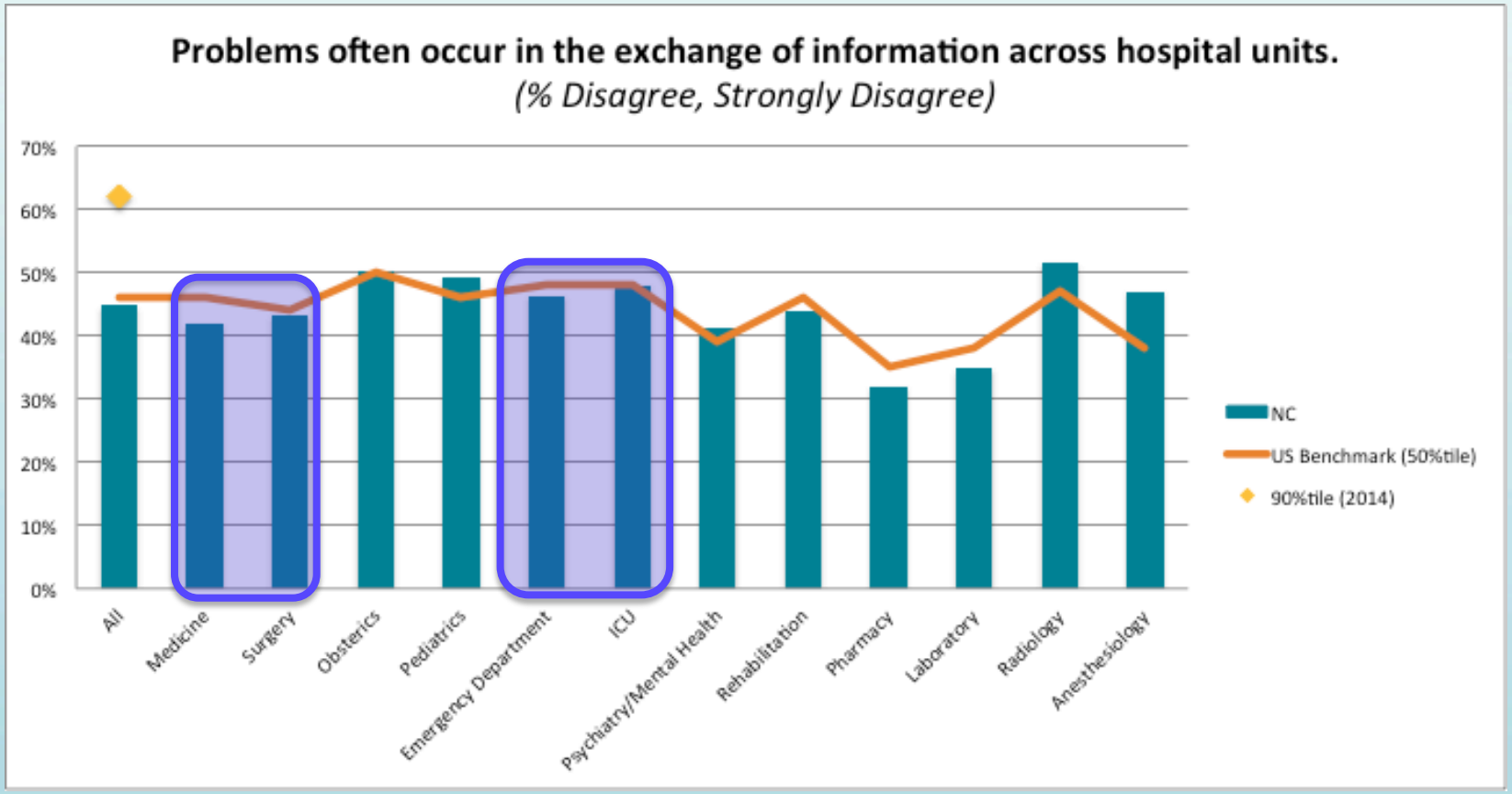
HSOPS Survey: Problems often occur in the exchange of information…



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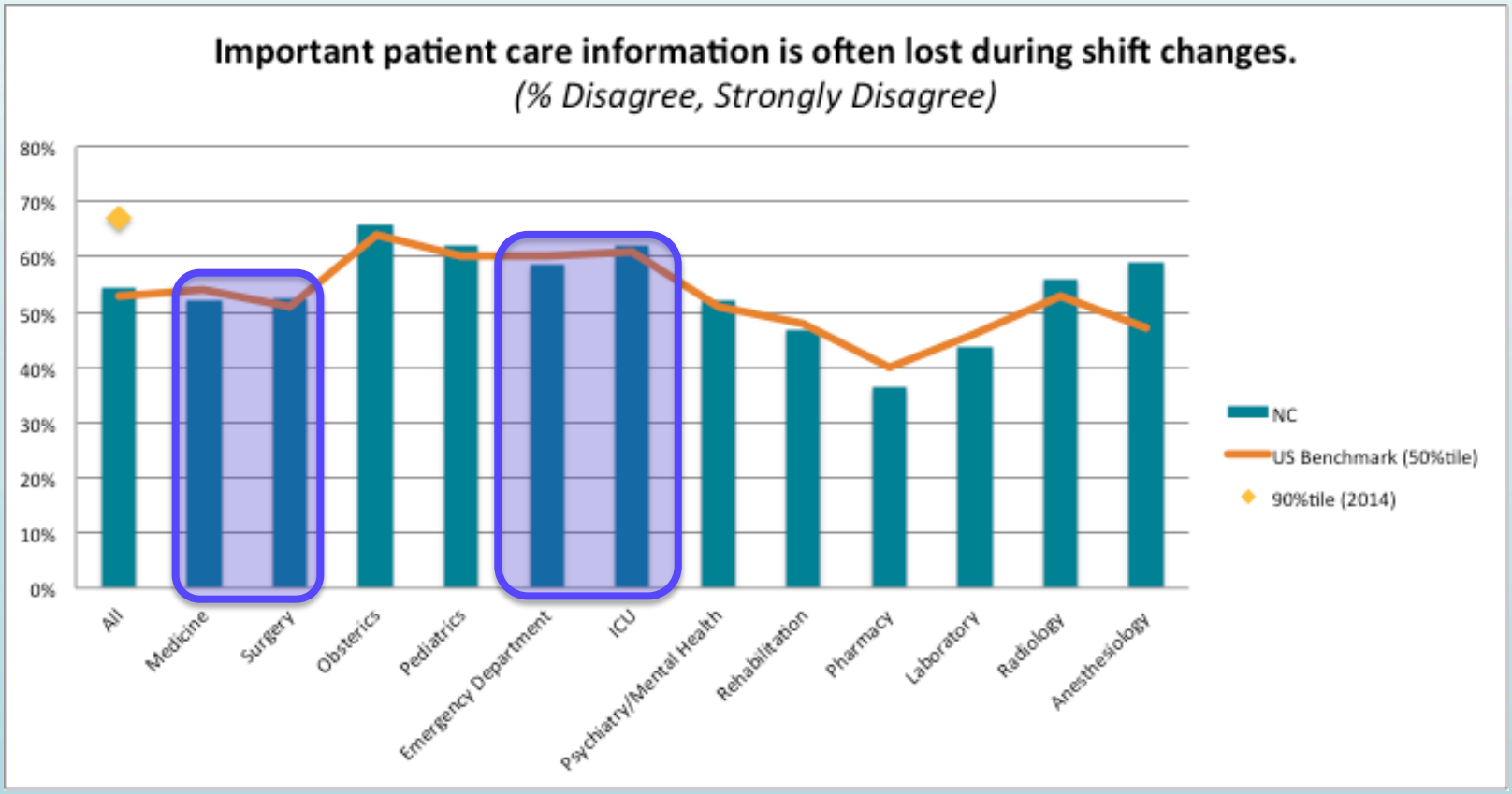
HSOPS Survey: Important information is often lost during shift change



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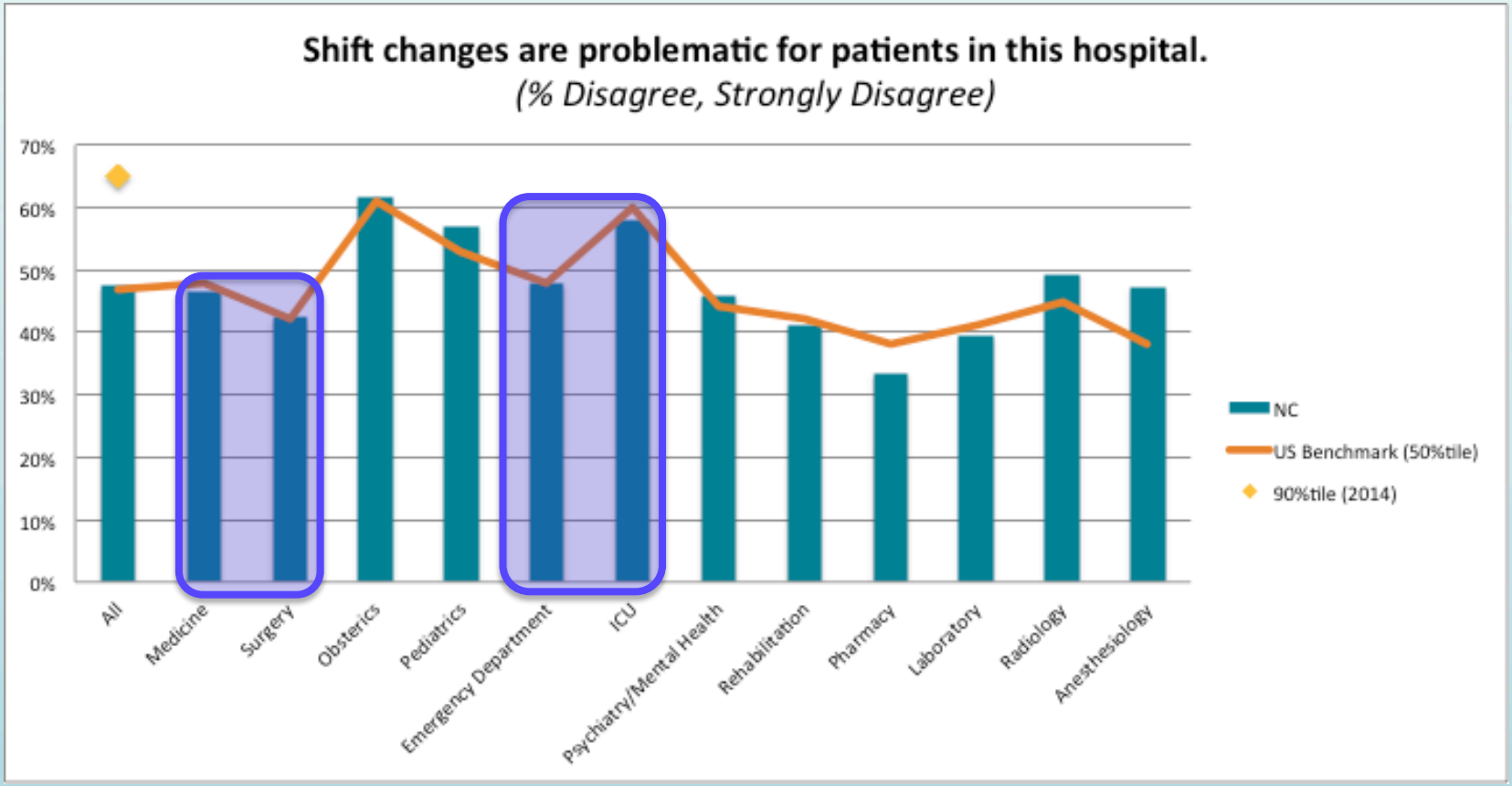
HSOPS Survey: Shift changes are problematic…



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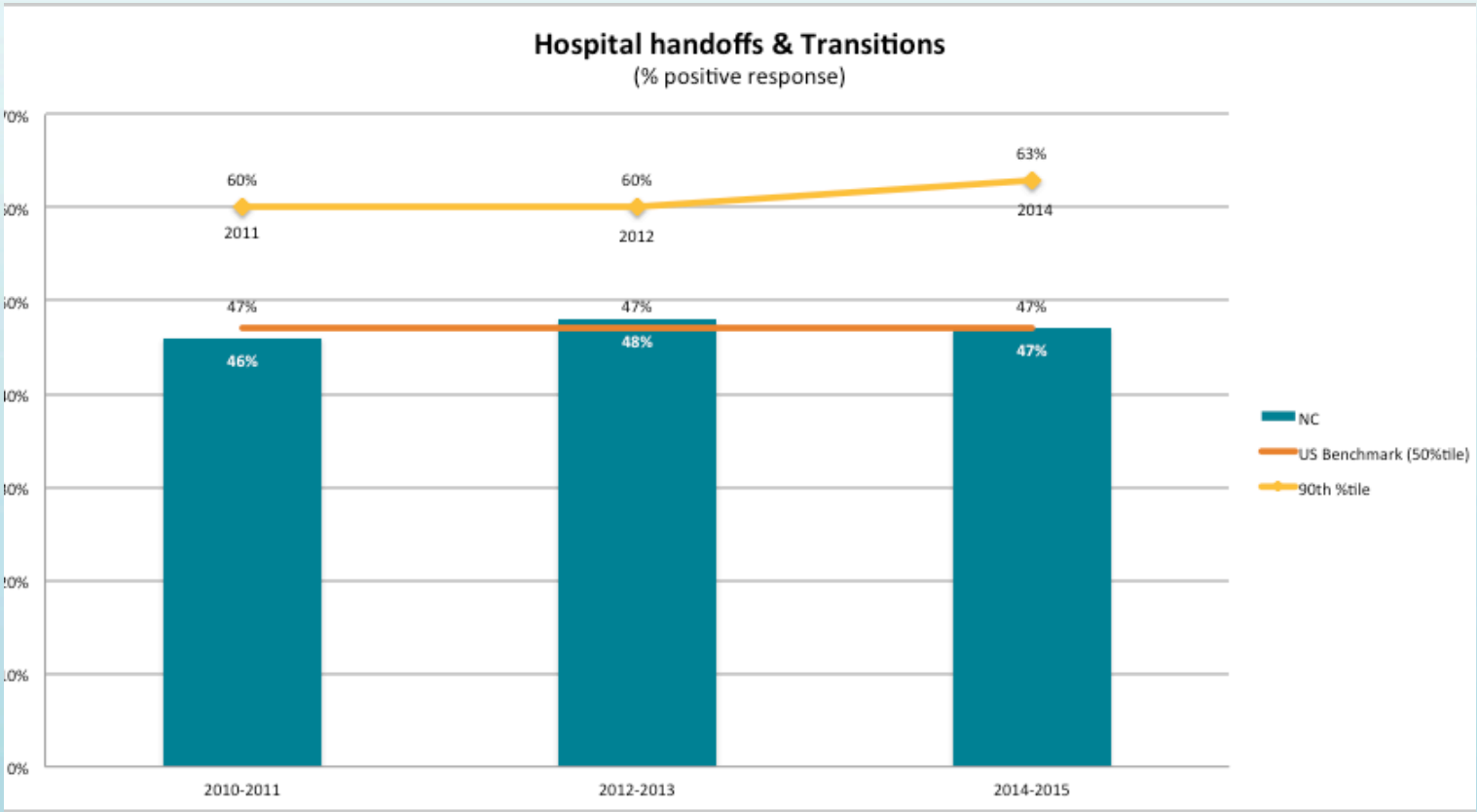
HSOPS Survey: What has changed in Hospital Handoffs & Transitions?



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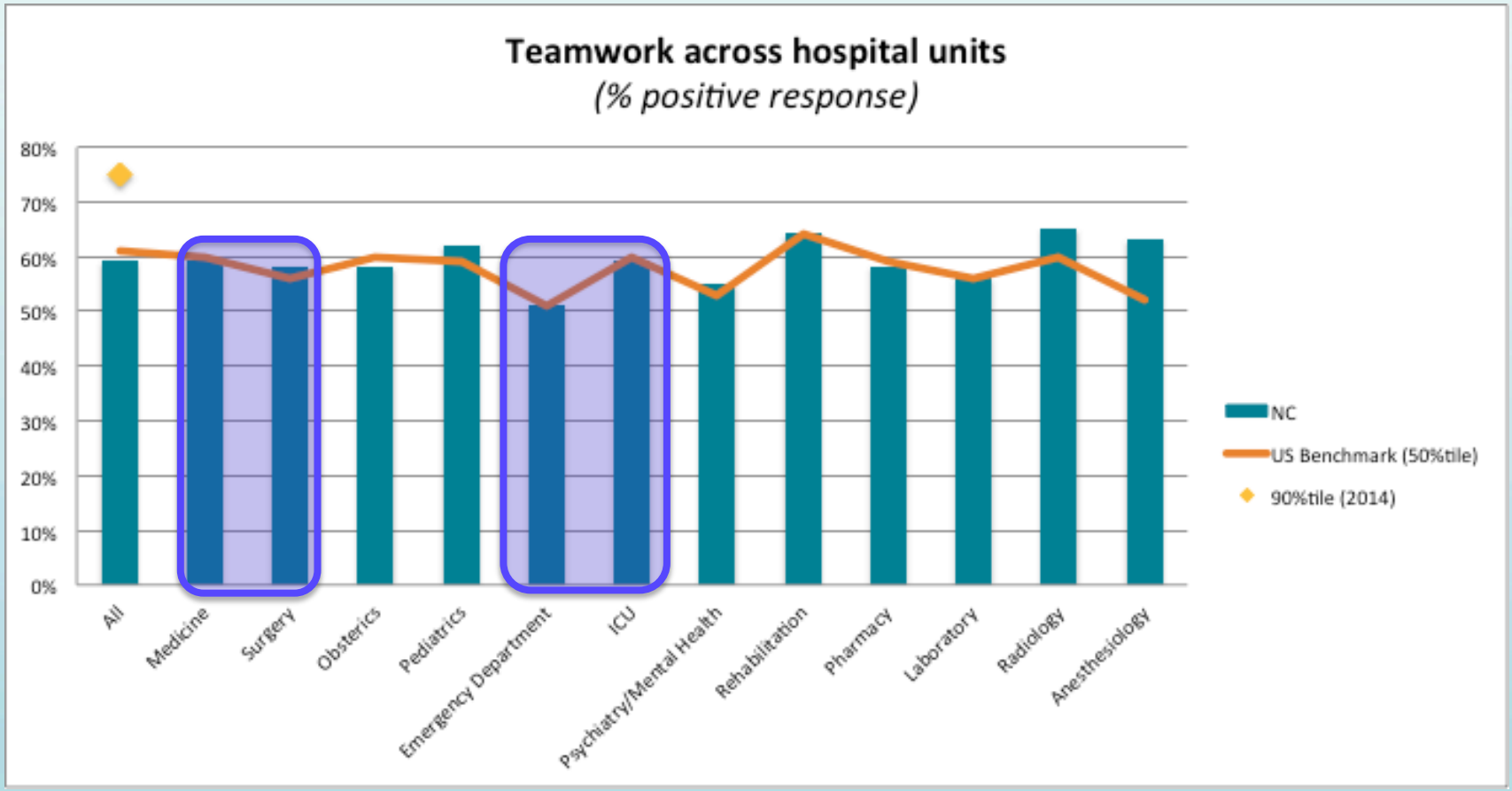
HSOPS Survey: Teamwork Across Hospital Units Dimension

- There is good cooperation among hospital units that need to work together.
- Hospital units work well together to provide the best care for patients.
- **Hospital units do not coordinate well with each other.**
- It is often unpleasant to work with staff from other hospital units.

HSOPS Survey: Teamwork Across Hospital Units - Overall



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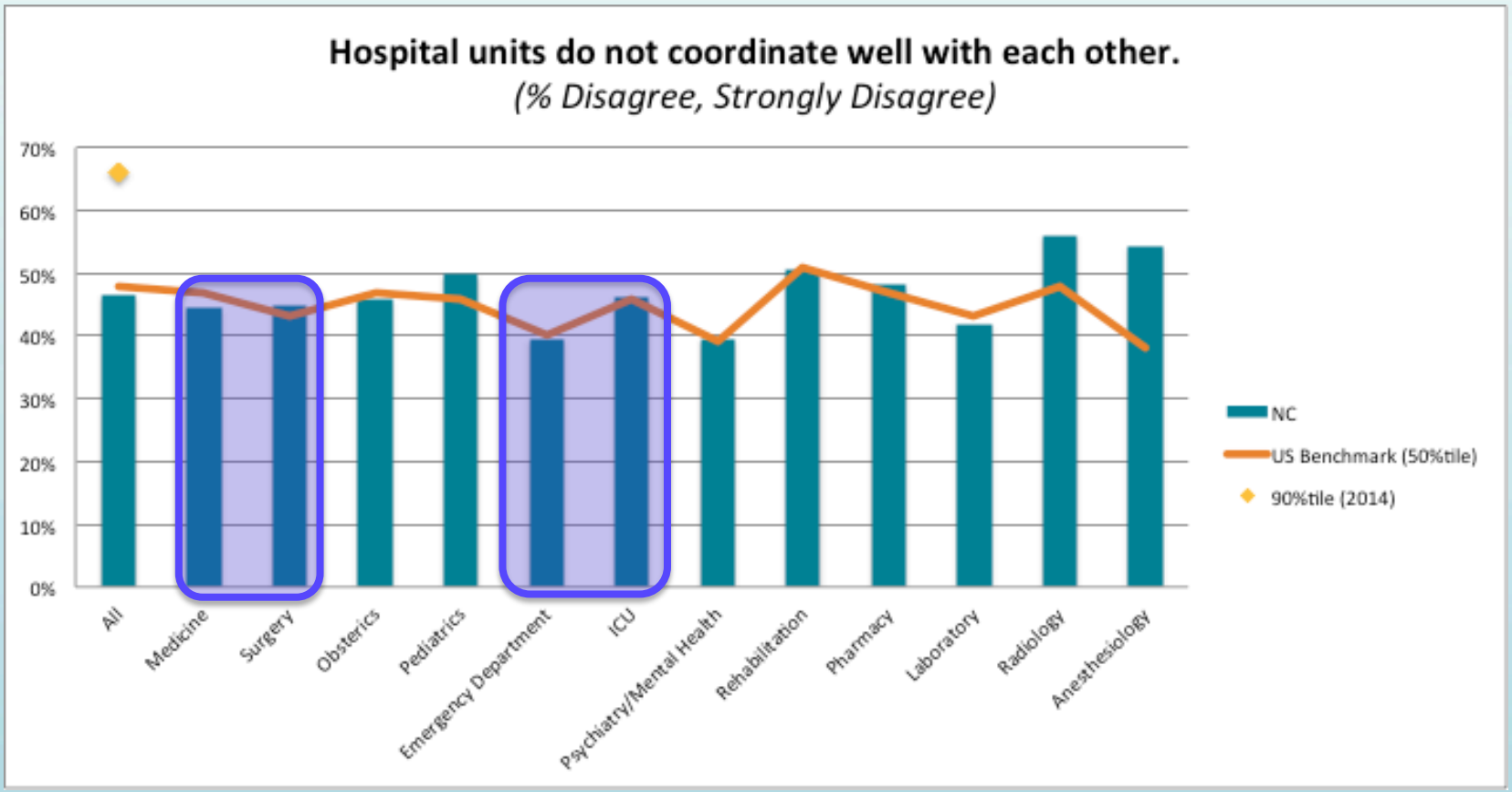
HSOPS Survey: Hospital Units Do Not Coordinate Well With Each Other



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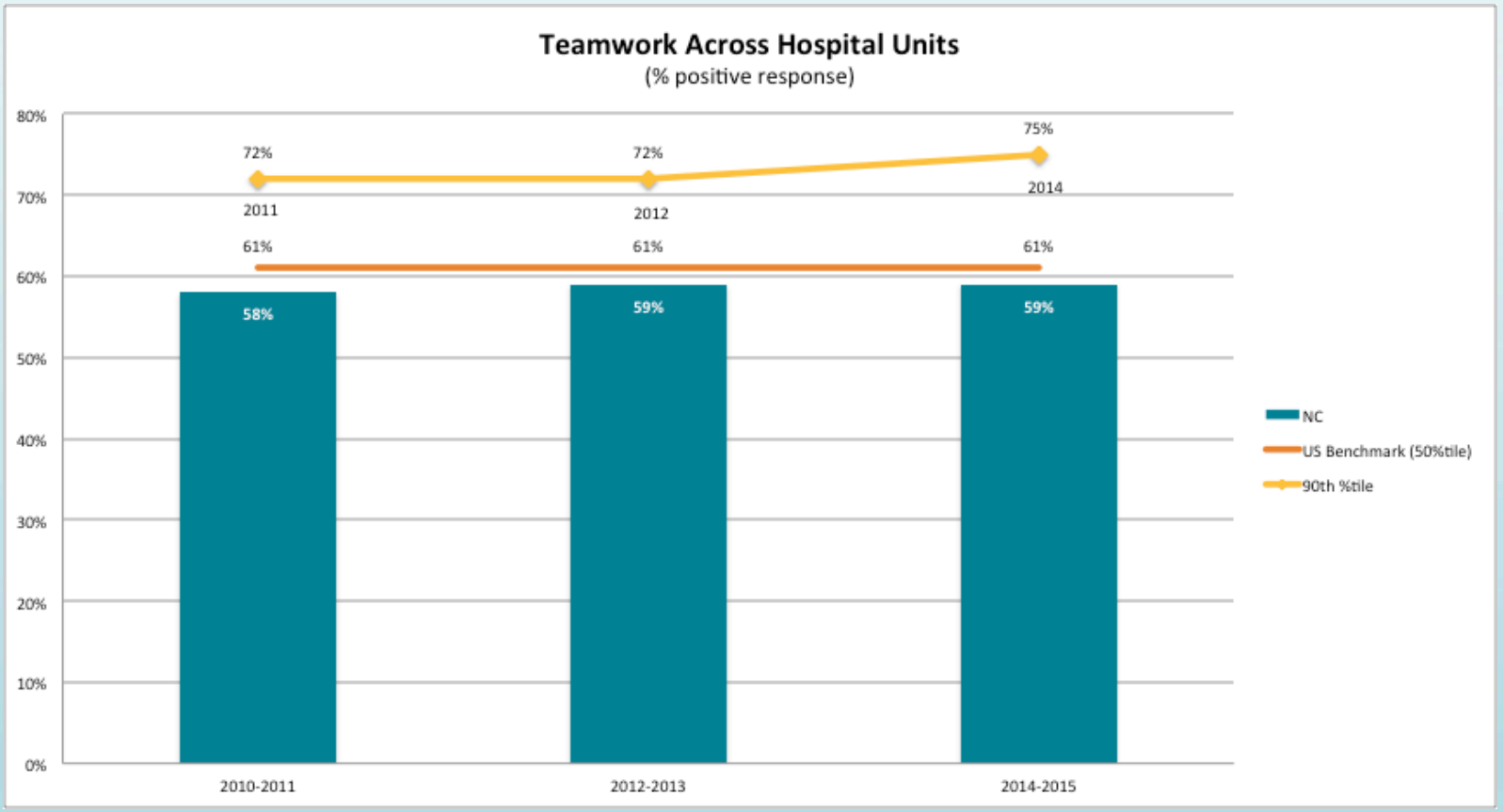
HSOPS Survey: What has changed in Teamwork Across Hospital Units?



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What is your “Reality vs Perception?”

Have you correlated actual events with patient safety culture survey data to evaluate handoff communication?

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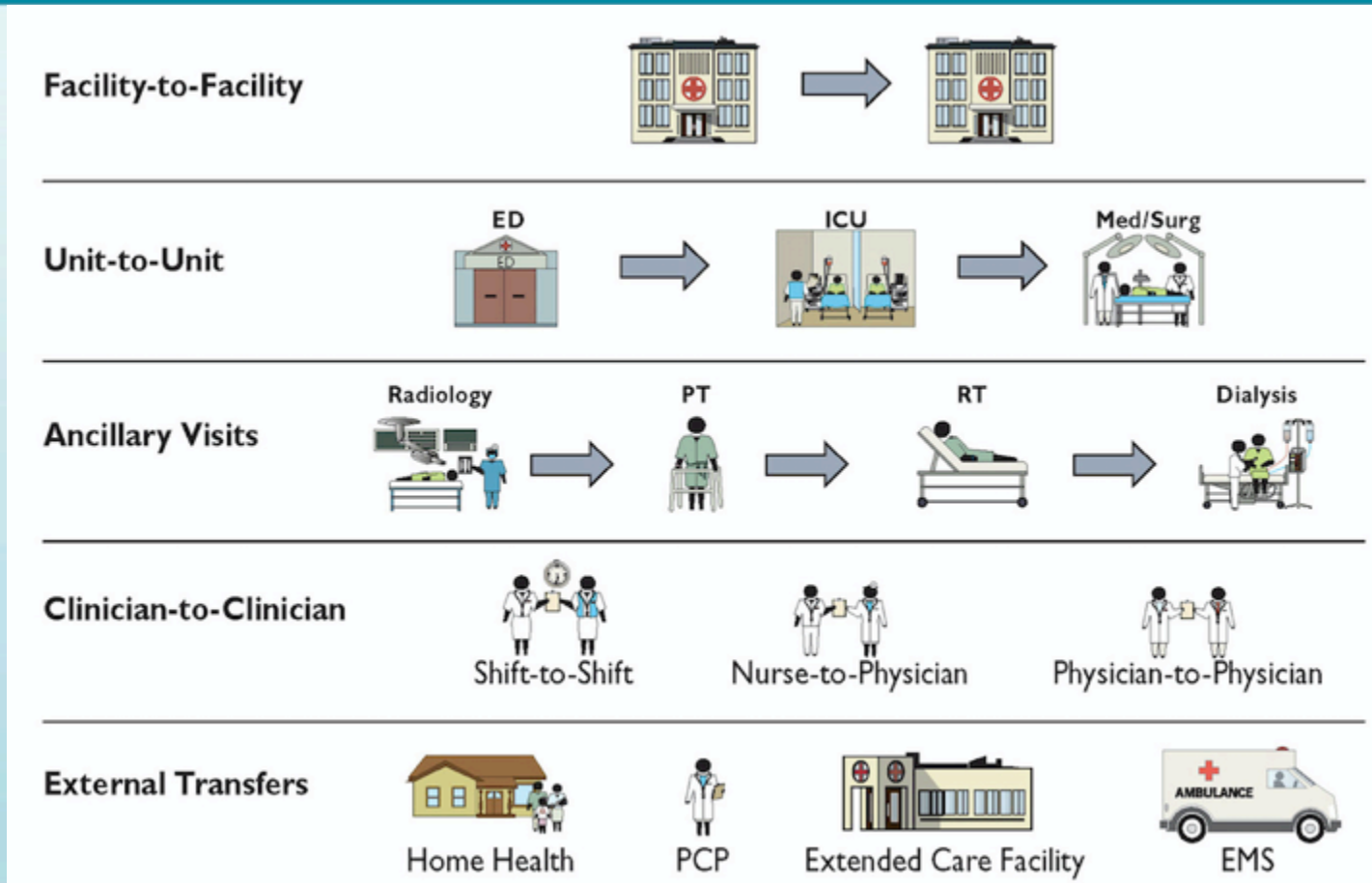
Multiple Chances for Error



What Makes a Good Handoff?

Culture

People

Process

Tools

Goals:

Transfer of Professional Responsibility

Ensure transfer of accurate & unambiguous information

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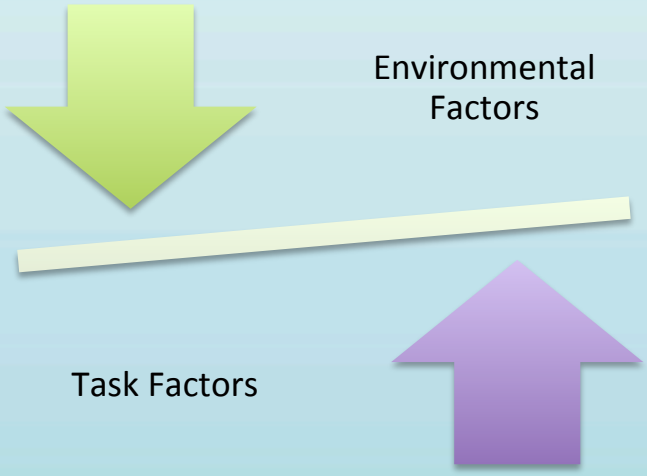
Handoffs: *Not Yet Getting it Right*

Information:
- TMI
- Missing critical data
- Untimely data
- Inaccurate data
- Poorly organized
- CoPaGA
- Inconsistent

Use various tools:
- SBAR, ANTICipate, I PASS the BATON
- Technology
- Verbal report (unstructured)
- Other

Handoffs are not:
- Standardized
- Taught



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Handoff Process

Pre-handoff	Initiate	Dialogue	Post-handoff
Sender organizes & updates handoff information	Stop patient care tasks to conduct handoff	Specific verbal exchange between sender and receiver	Receiver integrates new information and assumes care
• Lack of time, poor time management, fatigue, or work prevent updating • Lack of clinical judgment to construct proper handoff • Vague language	• No set location or time • Not able to contact sender or receiver • Competing obligations (work or personal) • Handoff not a priority over tasks	***Sender could*** • Provide disorganized info • Use vague or unclear language • Fail to provide clinical impression (what is wrong), anticipatory guidance (if/then), plan (to do), & rationale (why) ***Receiver could*** • Not listen (distractions) • Misunderstand • Not clarify (ask questions)	• Forget key tasks or information • Not document actions taken • Act on plan without taking new information into account • Not invest in the care of patient (lack of professional responsibility)

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Common Handoff Tools

SBAR

- Situation
- Background
- Assessment
- Recommendations

ANTICipate

- Administrative data
- New clinical information
- Tasks to be performed
- Illness severity
- Contingency plans

IPASS

- Illness Severity
- Patient Summary
- Action List
- Situation Awareness & Contingency Planning
- Synthesis by Receiver

SBAR Use

- Originated in Navy to communicate critical situations
- Introduced in healthcare as part of Crew Resource Management training
- Adapted for nurse to physician communication

SBAR is a technique designed to communicate critical information succinctly and briefly.

S ituation

What's going on with the patient right now?
(Identify yourself. Identify the patient. State the problem concisely.)

B ackground

What's the background on this patient? How did we get to this point? *(Review the chart. Anticipate questions. State the relevant medical issues.)*

A ssessment

What do I think the issue is? Why am I concerned?
(Provide your observations and evaluations of the patient's current state.)

R ecommendation

What should we do to respond to the situation?
(Suggest what should be done to meet the patient's immediate needs.)

SBAR for Handoffs

S: Situation	Patient problems, diagnosis, treatment plan and patient immediate concerns
B: Background	Admit date, code status, vital signs, list of medications, pertinent clinical information related to care and laboratory results
A: Assessment	Current care provider's assessment of the situation
R: Recommendation	Identify pending lab results, treatment given and response, what needs to be done in the next shift and other care recommendations. Restate concerns and respond to questions.

I-PASS Mnemonic

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Timeline and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Starmer, A.J., Spector, N.D., Srivastava, R., Allen A.D., Landrigan C.P., Sectish T.C., et al. "I-PASS, a Mnemonic to Standardize Verbal Handoffs." Pediatrics. 129.2 (2012): 201-204.

Situation Awareness & Contingency Planning

S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen

Situational Awareness
"Know What is Going On"

- Patient Level
- Team Level

Shared Mental Model

Cross Checking

Contingency Planning
Problem solve before things go wrong…

- "If this happens, then…"
- List interventions that have/ have not worked
- Consider code status
- "I don't anticipate any problems"

Synthesis By The Receiver

S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

- Provide details based on receiver's
  - Level of experience
  - Knowledge of disease process
  - Familiarity with service and/or patient
- Demonstrates information is received & understood
- Ensures transfer of information & responsibility
- Promotes a shared mental model

Using TeamSTEPPS in Handoffs

Cross Monitoring	Night team recognizes medication error during handoff and informs the day team
Brief	Night team goes over action list and divides tasks and new admits and plans for time to regroup
Debrief	In the morning, the night team and day team discuss what went well with the handoff and items the night team would have liked to know
Huddle	A patient is unstable, the day and night team examines the patient together and discusses plans for the night with the nurse
Check-Back	The intern obtains new information to add to the hand off from the senior resident, this information is repeated by the intern to confirm communication

Shift Reports: Asking Questions

Question Type by Provider Group

Provider Type	Average questions asked	Confirming status, response or Treatment	Planning tasks, workflow, timing	Consensus of clinical reasoning	Framing and alignment
Nurses	4.25	49	47	26	58
Physicians	2.8	34	34	41	27
NPs	4.0	2.8	19	33	15

Social interaction impacts *what* and *how* information is shared.

O'Brien, C., Flanagan, M., Bergman, A., Ebright, P., & Frankel, R. (2015). "Anybody on this list that you're more worried about" *BMJ Qual Saf*, bmjqs-2014-003853. http://dx.doi.org/10.1136/bmjqs-2014-003853

Shift Reports: Conflicting Staff Dynamics

Outgoing Nurse

- Transfer care
- Need to get home

Value:

- No interruptions

Incoming Nurse:

- Multi-tasking
- Need to check patient's condition

Value:

- Eye contact and
- Opportunity to ask questions

Relational Communication
Perceptions of psychological safety, trust and respect that encourage sharing and learning and positive energy

Carroll, J., Williams, M., & Gallivan, T. The ins and outs of change of shift handoffs between nurses: a communication challenge. BMJ Qual Saf 2012; 21:586-593.

Handoff Measures

- Content
  - Completeness and accuracy of information
- Process
  - Environmental
  - Behavioral
  - Hospital Survey on Patient Safety Culture (Handoffs)
- Outcome
  - Satisfaction with handoff and safety
  - Impact of subsequent care
  - Event reporting

JCCTH: The Solutions

- Standardize critical content
- Hardwire within your system
- Allow opportunity to ask questions
- Reinforce quality and measurement
- Educate and coach
- Don't forget teamwork

Joint Commission Center for Transforming Healthcare

Journal on Quality and Patient Safety. (2010, February). Understanding and Improving Patient Handoffs, 50-72.

Handoff Education

1. Didactic session that teaches techniques and concepts
2. Handoff simulation
3. Computer module learning
4. Resources to educate and train
5. Observation & feedback tools
6. Campaign handoff toolkit

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Handoff Practice

SBAR

S: Situation

B: Background

A: Assessment

R: Recommendation

IPASS

I: Illness Severity

P: Patient Summary

A: Action List

S: Situation Awareness and Contingency Planning

S: Synthesis by Receiver

NCQC Upcoming Webinars

Topic	Date
Physician Leadership & Patient Safety	Nov 17th
Cape Fear Valley's Patient Safety Journey	Dec 8th
The Second Victim Program	Jan 21st 2016
Psychiatric Medications in the ED	Feb 2016

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Thank You for Sharing!

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