NC QC PSO & CHPSO Present

Safer Handoffs – Part 4

The North Carolina Quality Center PSO

CHPSO

Housekeeping

- All lines will be muted during the webinar
- To ask a question chat your question in
- The slides and recording for this webinar will be made available through your PSO

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Patient Safety Listed PSO Organization

Safer Handoffs - Part 4

Klaus Nether, MT (ASCP) SV, MMI
Master Black Belt
Training Lead
Robust Process Improvement
Joint Commission Center for Transforming Healthcare

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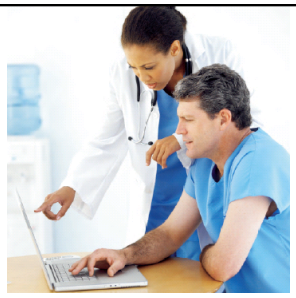

The Center for Transforming Healthcare and the Hand-off Communications (HOC) Targeted Solutions Tool (TST)

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Overview

- Introduction to the Joint Commission Center for Transforming Healthcare (CTH)
- Overview of Hand-off Communications Project
- Targeted Solutions Tool (TST) for Hand-off Communications

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Introduction to CTH-Challenge

- More than 400,000 harmful, preventable, bad outcomes occur in hospitals every year
- Costs associated with unsafe care and poor quality in hospitals are unacceptable
- Strong demand from health care organizations for specific guidance on how to solve these problems
- Organizations want highly effective, durable solutions and are ready to implement them

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Introduction to CTH-Challenge

- Current "best practice" approach is lacking
  - Often difficult to achieve same results
- Checklist approach is limited
- Fail to recognize:
  - Many causes for the same problem
  - Each cause requires a different strategy
  - Key causes differ from place to place
- New generation produces a set of solutions, customized to address an organization's most important root causes

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Introduction to CTH-Mission

- Our Mission - Transform health care into a high reliability industry and to ensure patients receive the safest, highest quality care they expect and deserve
- Presents a new approach to address critical safety and quality problems sought by The Joint Commission, health care organizations, patients and their families, physicians and other clinicians, and other public and private stakeholders

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Participating Hospitals

- Barnes-Jewish
- Baylor
- Cedars-Sinai
- Cleveland Clinic
- Exempla
- Fairview
- Froedtert
- Intermountain
- Johns Hopkins
- Kaiser-Permanente
- Mayo Clinic
- Memorial Hermann
- NY-Presbyterian
- North Shore-LIJ
- Northwestern
- OSF
- Partners HealthCare
- Stanford Hospital
- Trinity Health
- Virtua
- Wake Forest Baptist
- Wentworth-Douglass

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Introduction to CTH- Operating Model

- Robust Process Improvement (RPI) methodology to determine individual organization root causes to problem
  - RPI is Lean Six Sigma integrated with change management for acceptance and accountability
  - Target validated solutions to those unique root causes

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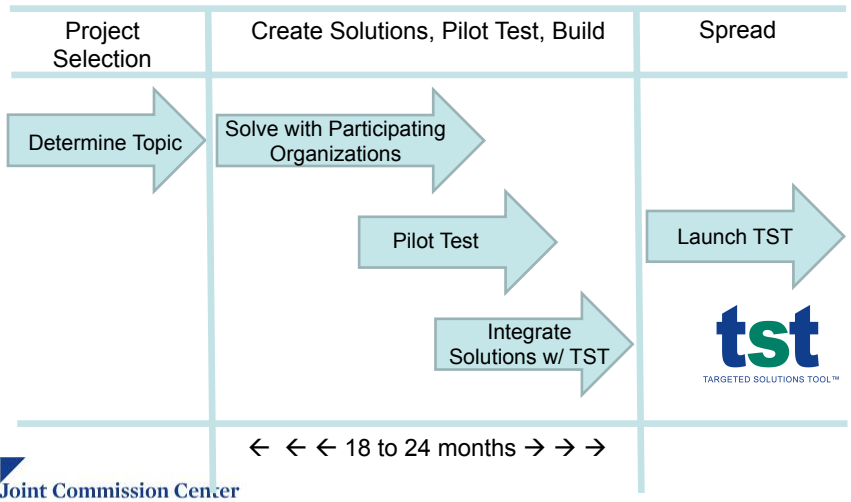
Center Operating Model



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Introduction to CTH-Projects

- Project 1 – Hand Hygiene Compliance
- Project 2 – Wrong Site Surgery
- Project 3 – Hand Off Communication
- Project 4 – Surgical Site Infections
  - With American College of Surgeons
- Project 5 – Preventing Avoidable Heart Failure Hospitalizations
  - With American College of Physicians
- Project 6 – Safety Culture
- Project 7 – Preventing Falls with Injury
- Project 8 – Reducing Sepsis Mortality
- Project 9 – Medication Safety

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Center Projects
Targeted Solutions Tool

- Project 3 – Hand Off Communication (HOC)
  - TST Launch June 2012

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HAND-OFF COMMUNICATIONS

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The Center's Second Patient Safety Challenge

- Ten leading hospitals and health systems collaborated to identify solutions for the Center's second project on targeting breakdowns in hand-off communications
  - Exempla Lutheran Medical Center, Wheat Ridge, CO
  - Fairview Health Services, Minneapolis, MN
  - Intermountain Healthcare LDS Hospital, Salt Lake City, UT
  - The Johns Hopkins Hospital, Baltimore, MD
  - Kaiser Permanente Sunnyside Medical Center, Clackamas, OR
  - Mayo Clinic Saint Mary's Hospital, Rochester, MN
  - New York-Presbyterian Hospital, New York, NY
  - North Shore-LIJ Health System Steven and Alexandra Cohen Children's Medical Center, New Hyde Park, NY
  - Partners HealthCare Massachusetts General Hospital, Boston, MA
  - Stanford Hospital & Clinics, Stanford, CA

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HAND-OFF COMMUNICATIONS

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Why Tackle Hand-off Communications?

- Health care organizations have long struggled with the process of passing necessary and critical information about a patient from one caregiver to the next, or from one team of caregivers to another
- An estimated 80 percent of serious medical errors involve miscommunication during the hand-off between medical providers

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HAND-OFF COMMUNICATIONS

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What is Hand-off Communication?

- A hand-off is the transfer and acceptance of patient care responsibilities achieved through effective communication
- The hand-off process involves "senders" – the caregivers transmitting patient information and releasing the care of the patient to the next clinician, and "receivers" – the caregivers who accept patient information and care of the patient

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HAND-OFF COMMUNICATIONS

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What was Measured? Defective Hand-offs

- A 'defective' hand-off occurs when the hand-off did not meet the needs of either the sender or the receiver

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HAND-OFF COMMUNICATIONS

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Validated Root Causes for Transition of Care: Hand-off Communications Failures

All participating hospitals

		A	B	C	D	E	F	G	H	I	J
General	Culture does not promote successful hand-off, e.g. lack of teamwork and respect	x	x	x		x		x		x	x
	Expectations between sender and receiver differ	x	x	x		x		x		x	x
	Ineffective communication method, e.g. verbal, recorded, bedside, written	x				x		x	x	x	x
	Timing of physical transfer of the patient and the hand-off are not in sync		x			x	x	x		x	x
	Inadequate amount of time provided for successful hand-off	x	x	x		x	x				
	Interruptions occur during hand-off			x		x	x				
	Lack of standardized procedures in conducting successful hand-off, e.g. SBAR			x	x	x		x			
	Inadequate staffing at certain times of the day or week to accommodate successful hand-off					x	x				
	Patient not included during hand-off	x									
	Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/ issues, contact information	x	x	x	x	x	x	x	x	x	x
Sending	Sender, who has little knowledge of patient, is handing off patient to receiver	x		x	x	x			x	x	x
	Sender unable to provide up-to-date information, e.g. lab tests, radiology reports, because not available at the time of hand-off					x	x				x
	Sender unable to contact receiver who will be taking care of patient in a timely manner					x		x			
	Inability of sender to follow up with receiver if additional information needs to be shared						x				
	Sender asked to repeat information that has already been shared					x					
Receiving	Receiver has competing priorities and is unable to focus on transferred patient					x				x	x
	Receiver unaware of patient transfer					x			x		
	Inability for receiver to follow up with sender if additional information is needed						x				
	Lack of responsiveness by receiver	x									
	Receiver has little knowledge of patient being transferred					x					

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Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

Hand-Off Communications (HOC)

- In October 2010, the Center announced targeted solutions for improving the quality of hand-off communications
- By using solutions targeted to the specific causes of an inadequate hand-off, participating organizations that had fully implemented solutions achieved on average close to a 60 percent reduction in defective hand-offs

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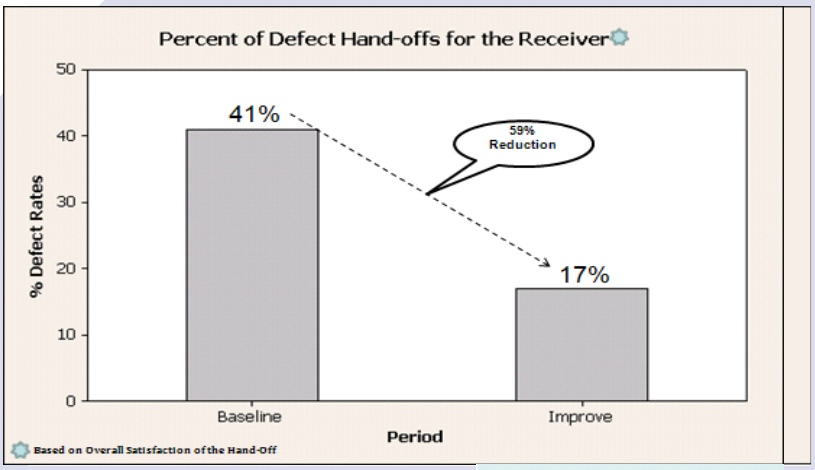
HAND-OFF COMMUNICATIONS

Hand-off Communications Performance Improvement Measure



* This Bar Chart represents aggregated data from participating hospitals (N=7) that have completed improvements, to date.

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Hand-Off Communications (HOC)

- In 2011, targeted solutions for hand-off communications were pilot tested in hospitals and ambulatory care settings to prove their effectiveness in demographically diverse hospitals and other care settings
- Both hospital and ambulatory pilot settings experienced a decrease in defects

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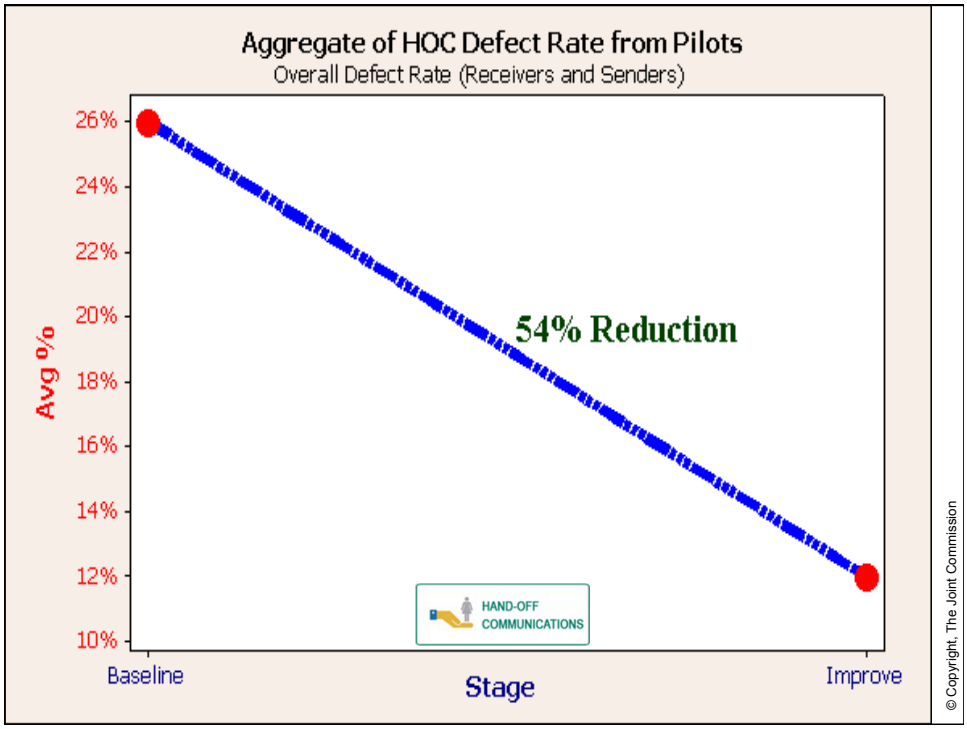

Did improved HOCs impact anything else?

- Outcome Metrics
  - Reduction in readmission rates
  - Reduction in bounce backs
  - Reduction in LOS in ED
  - Improved Patient Satisfaction
  - Improved Family Satisfaction
  - Improved Staff Satisfaction

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Hand-Off Communications (HOC)

- Targeted hand-off solutions from the Center use the acronym "SHARE" to address steps to ensure a successful hand-off:
  - **S**tandardize Critical Content
  - **H**ardwire Within Your System
  - **A**llow Opportunity to Ask Questions
  - **R**einforce Quality and Measurement
  - **E**ducate and Coach

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Hand-off Communications

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TARGETED SOLUTIONS TOOL™

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Introduction to CTH-Spread

- Improvement spread through Targeted Solutions Tool™
  - Web-based tool free to Joint Commission accredited organizations
  - No knowledge of RPI methodology needed
  - Data analysis conducted by the tool, not the user
  - Tool walks user through process of:
    - Measuring current state
    - Determining root causes
    - Selecting targeted solutions
    - Control of process after implementation

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How To Spread Improvement?

- To maximize impact, improvement knowledge must be able to reach healthcare organizations of varying sizes and capabilities
- Leverage reach of 19,000 accredited organizations
- CTH developed simple assessment and problem solving tools for hospitals without RPI capacity
  - Measure process (e.g., hand hygiene)
  - Assess specific causes of failures
  - Match interventions to hospital's causes
- Engaging industry in Center projects

TARGETED SOLUTIONS TOOL™

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Overall Concept of Targeted Solutions Tool

TARGETED SOLUTIONS TOOL™

- Tool then walks individual through steps of a project
  - Gathering the project team and being successful
  - Training data collectors
  - Collecting baseline data
  - Tool conducts data analysis
  - Solution based on root causes provided
  - Post-implementation and on-going data collection

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Polling Question

- Is your organization Joint Commission Accredited?
  1. Yes
  2. No

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Polling Question

- Are you aware of the Targeted Solutions Tool (TST?
  1. Yes
  2. No

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Polling Question

- If you are aware of the TST have you previewed it to see what it contains?
  1. Yes
  2. No

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Polling Question

- Are you currently using the TST?
  1. Yes
  2. No

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Polling Question

- Would your organization be interested in using the TST to improve handoffs?
  1. Yes
  2. No
  3. Maybe

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Handoff Technology Solutions

- EMRs considerable success with automated logs to document transfers
  - Use of technology is still rare and evolving
- Kaiser Nurse Knowledge Exchange computer program
  - Allows departing nurses to create customized electronic report on patients for incoming nurses

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Handoff Technology Solutions

- Research study conducted use of electronic tools during nursing handoffs
  - Two-thirds nurses abandoned use of electronic handoff form, preferred paper form
  - Findings suggest effective electronic solutions will require extensive contextually-based information
    - Information integrated across EHR modules
    - Portable, electronic support throughout shifts

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CHPSO Member Hospital
Guest Presenter-Technology Solutions

Jennifer Berg, BSN, RN, CWOCN
Patient Safety Officer
ValleyCare Health System

- ValleyCare Health System is an intricate part of the Tri-Valley and surrounding communities, and has provided state-of-the–art, top quality health care to local families since 1961.
- ValleyCare has a total of 242 beds and a medical staff of over 300

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Technology Solution Questions

- **Define your technology solution:**
  - Diagnostic Imaging (DI) requisition already printing to ED upon order
  - Added SBAR fields to bottom of requisition for RN to complete prior to sending patient to radiology
- **How it works:**
  - Requisition prints in ED
  - RN completes SBAR portion
  - Requisition is given to DI technologist and goes with patient to radiology

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Technology Solution Questions

- **Identify pros and cons of your facility technology solution**: Pros: Staff do not need to remember to obtain a separate piece of paper to complete SBAR. Cons: Staff still have to hand write in information. Does not ensure compliance with process
- **Is it meeting your facility's needs for a technology solution for handoffs? If so, why; if not, why not?:** To completely meet our needs the information would be pulled from the ED EMR and only require verification by the RN prior to the patient being taken to diagnostic imaging.

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Contact Information

nschanz@ncha.org

bdietz@chpso.org

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