Transfer of Accountability – Ensuring Safe Patient Handoff

"How to Session"- D4

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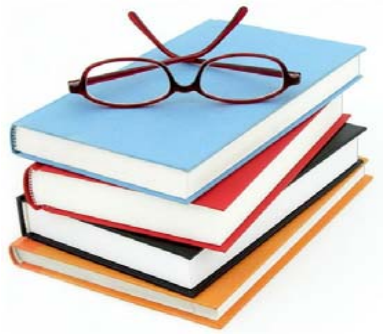
Communication and Patient Safety

- What percentage of error has been shown to be attributed to communication breakdown?

Communication Breakdown

- **70% !!**
- Communication failures are identified as the primary root cause in more than 70% of sentinel events
- Health Care Professionals receive little training in their basic programs on;
  - situational awareness
  - decision making
  - team work
  - communication



Communication

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Why is Communication Complicated?

Misunderstanding

Fatigue

Distractions

Non-verbal communication

Noise levels

assumptions

Interruptions

Workload

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If to Err is Human – Let's Talk About It!!

True or False?

- According to the Institute of Medicine's (IOM) widely circulated 1999 report "To Err is Human," up to 98,000 deaths occur each year as the result of clinical errors - more than are caused by motor vehicle accidents, breast cancer and AIDS combined.

True or False?

- The IOM report estimates that medical errors cost the country approximately $29 billion each year.

Reference:

http://www.ptsafety.org/whoweare/welcome.html

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Distractions and Interruptions are Everywhere….

Limits in Cognition – Human Factors Design

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- Attentional blindness
- Confirmation bias
- Short term memory; 7 +/- 2 units of information retained

RED BLUE GREEN BLUE PURPLE BLACK

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The Literature

- Conducting nurse-to-nurse shift report at the bedside, in the presence of the patient puts the patient central to all care activity information (Anderson & Mangino, 2006). It allows the outgoing nurse to introduce the incoming nurse to the patient, thus creating an explicit transfer of responsibility.

- Chaboyer, McMurray et al, 2009 reported that bedside handover improved safety, efficiency, teamwork and the level of support from senior staff.

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TRANSFER OF ACCOUNTABILITY

According to the College of Nurses of Ontario (2008),
Transfer of Accountability is defined as:

"an interactive process of transferring client specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity of care and the safety of the client."

What Does Transfer of Accountability Mean at Trillium?

TOA means that at the bedside, in front of the patient……..

The incoming nurse:

- Greets her patients
- Accepts accountability for her patients at a defined point in time
- Obtains full knowledge of the actual status of her patients
- Asks questions and clarifies information
- Confirms that her patients are safe at time of transfer

The outgoing nurse:

- Ensures information given was understood by incoming nurse
- Provides opportunities for patient/family involvement
- Has full knowledge of the condition of the patient at point of TOA
- Says goodbye to her patients

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TOA …….at the bedside

- Nurses greet the patient, oncoming nurse writes name on whiteboard
- Ask permission to give report at the bedside, address visitors
- Stand with back to room mate, speak in low tones, include patient/family in report
- Give verbal report utilizing standardized template
  - plan of care (medical history, Drs. orders, complications, goals, etc)
  - Patient status review (VS, head to toe assessment)
  - Bedside patient safety checklist (visual inspection, armband, allergies, I-V infusions, alarms on, risk concerns)

TOA

TOA is	TOA is **not…..**
■ a consistent process ■ a tool to support communication ■ a standard of care ■ a method to reinforce accountability ■ a process that improves patient and staff satisfaction ■ an effective improvement initiative; generated at the bedside	■ varied according to nurse ■ done blindly ■ done only when manager/clinical leader/educator are around ■ a temporary process to appease accreditation processes ■ yet another hospital initiative

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DISCUSS PATIENT STATUS & PLAN OF CARE

*Past medical history relevant to current situation *Medication administration issues
*Complications *Consults
*Shift orders and future one-time orders *Patient education (lovenox, falls prevention, etc.)
*Patient and family goals for the next 12 hours

Vital signs	e.g. BP range/meds, pulse, RR, O2sat, temp (cultures?antibiotics?antipytretics?)
Neurological	e.g. LOC, oriented x3, at risk for delirium?
Pain	e.g. scale 0-10, location, type, non-verbal cues, analgesics
Cardiovascular	e.g. CSM, edema? DVT? Calf pumping encouraged
Respiratory	e.g. O2, route, O2 sats, DB&C
Gastrointestinal	e.g. bowel sounds x 4 quad, last BM, ?ileus, N&V, diet
Genitourinary	e.g. foley? I&O, diuretics, >30cc/hr min. colour/odor?
Integumentary	e.g. incisions, pressure ulcers/Braden, treatment, reassessment and interventions, therapeutic surface
Musculoskeletal	e.g. ROM, mobility, activity level, transfers, aids,
Intravenous and Invasive lines/drains	e.g. IV/PICC, central line, site appearance, solutions, rates, pump set correctly/matches MD orders, Haemovac
LAB work and Diagnostic tests	e.g. results and treatment INR,K+,Hgb, urine cultures, blood work due/pending, X-ray, ECG
Family, psycho-social, Spiritual, cultural/linguistic issues	e.g. social, spiritual, cultural, family issues? Interpreter required? SW involved?
DISCHARGE Planning	e.g. date/time/location, CCAC, family support patient education complete?

Bedside Patient Safety Checklist

*visually inspect patient *Pt. armband on, allergies/alerts reviewed *IV solutions/infusions, PCA pumps
*Monitor alarms on *Risk concerns (falls, restraints,clutter) *Bed properly plugged into the wall

Case Scenario

- A 90 year old confused and pleasantly combative female; 10 day post repair of fracture hip.
- Well known to unit; placement challenges
- What issues do you anticipate?

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Enabling Change

Phase I
Opportunity Definition

Phase II
Designing & Planning

Phase III
Implementation

Define problem & Vision

Design Template

Revise prn

Support Staff with change

Data Collection

Create Ownership

Stages of Change

1. Immobilization/Denial – hurdles become evident
2. Incompetence/ Awareness – learning opportunities present
3. Acceptance of Reality - 'Letting go'.
4. Integration - Incorporation of value of the new initiative.

(Lewis-Parker Transition Curve)

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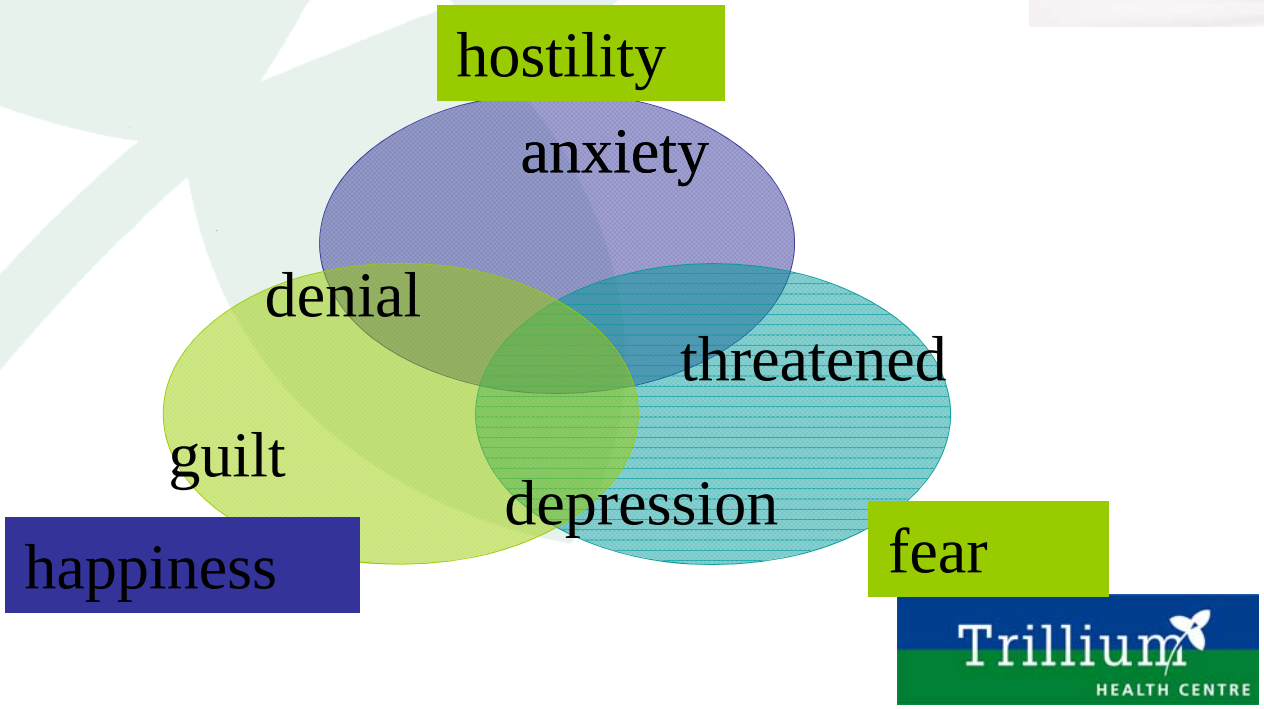
Change- Shouldn't be a "Bad" Word

- Lewis-Parker Personal Transition Curve; we have different responses to change
- Some of the responses are;



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Steps to Consider

1. Develop core group
2. Outline SMART goals
3. Stay focused on the benefits of the change initiative
4. Create ownership
5. Audit and revise prn
6. Create short-term wins
7. Keep Positive

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PLAN, DO, STUDY, ACT (PDSA Cycle)

- We may have to go through the cycle a few times before achieving success
- Take back the barriers/blips to the group and revise the template or process as appropriate
- Don’t look at barriers as failure

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Plan Do Study Act

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Project Measures/Indicators

- Positive patient and family feedback
- Patient satisfaction survey results
- Staff feedback
- Healthy workplace survey results

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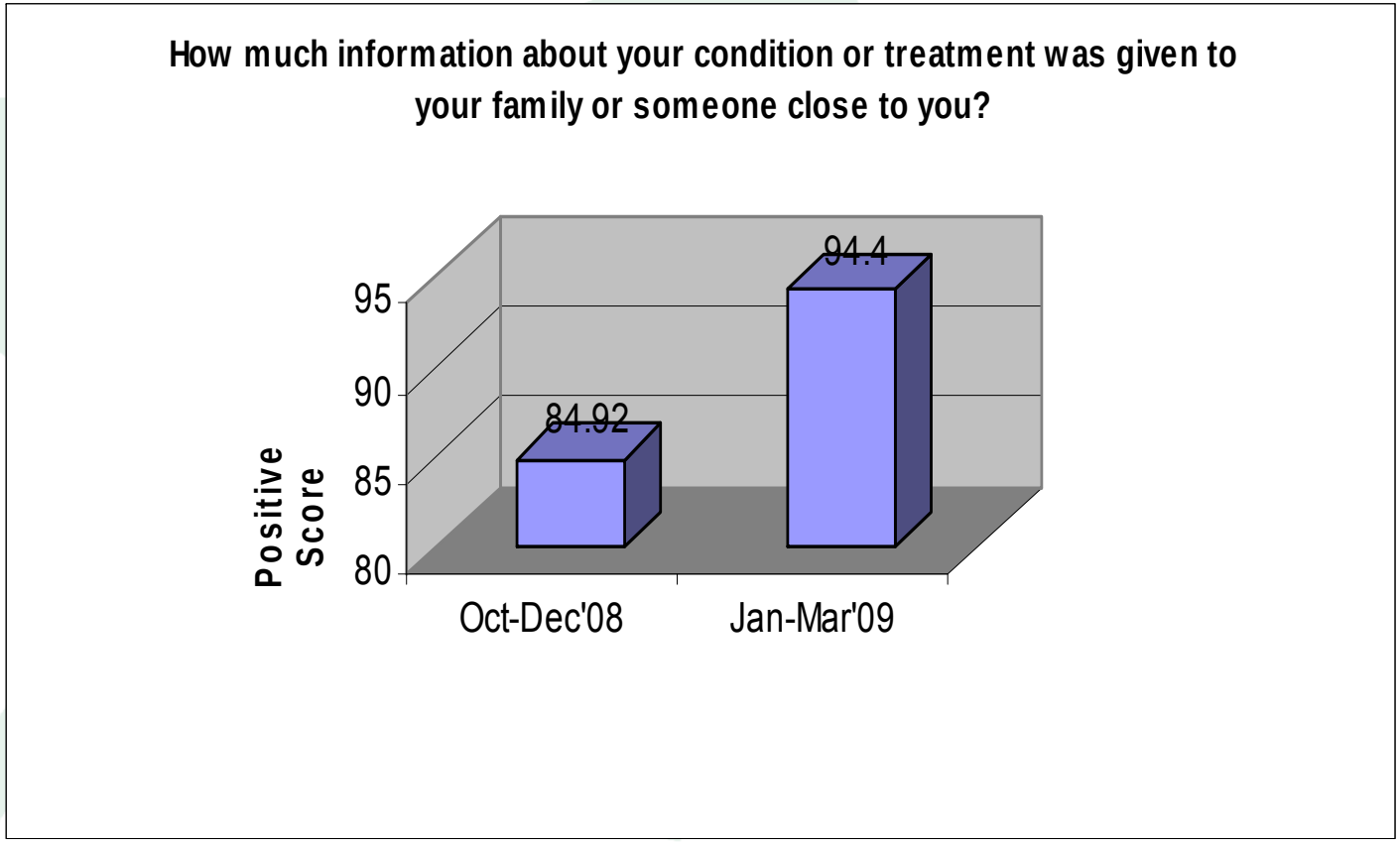
Picker Results



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TOA Patient Satisfaction Survey Results

Patient Survey	Patients	4		Patients	12		Patients	3	
	Week 1			Week 2			Week 3		
Weekly response totals	Yes	No	Sometimes	Yes	No	Sometimes	Yes	No	Sometimes
1. Do you like nurses giving report at the bedside in front of you?	4			12			3		
2. Does the nurse giving report at the bedside have any impact on how safe you feel?	4			11	1		3		
3. Do you know what is going on with your care every day?	3		1	12			3		
4. Do you feel included in bedside report?	3		1	11		1	2		1
5. Do you know who your nurse is at all times?	4			9	2	1	3		

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Project Measures/Indicators

Staff Feedback

- Healthy workplace survey results
- Staff survey
- Nursing TOA Process Audit

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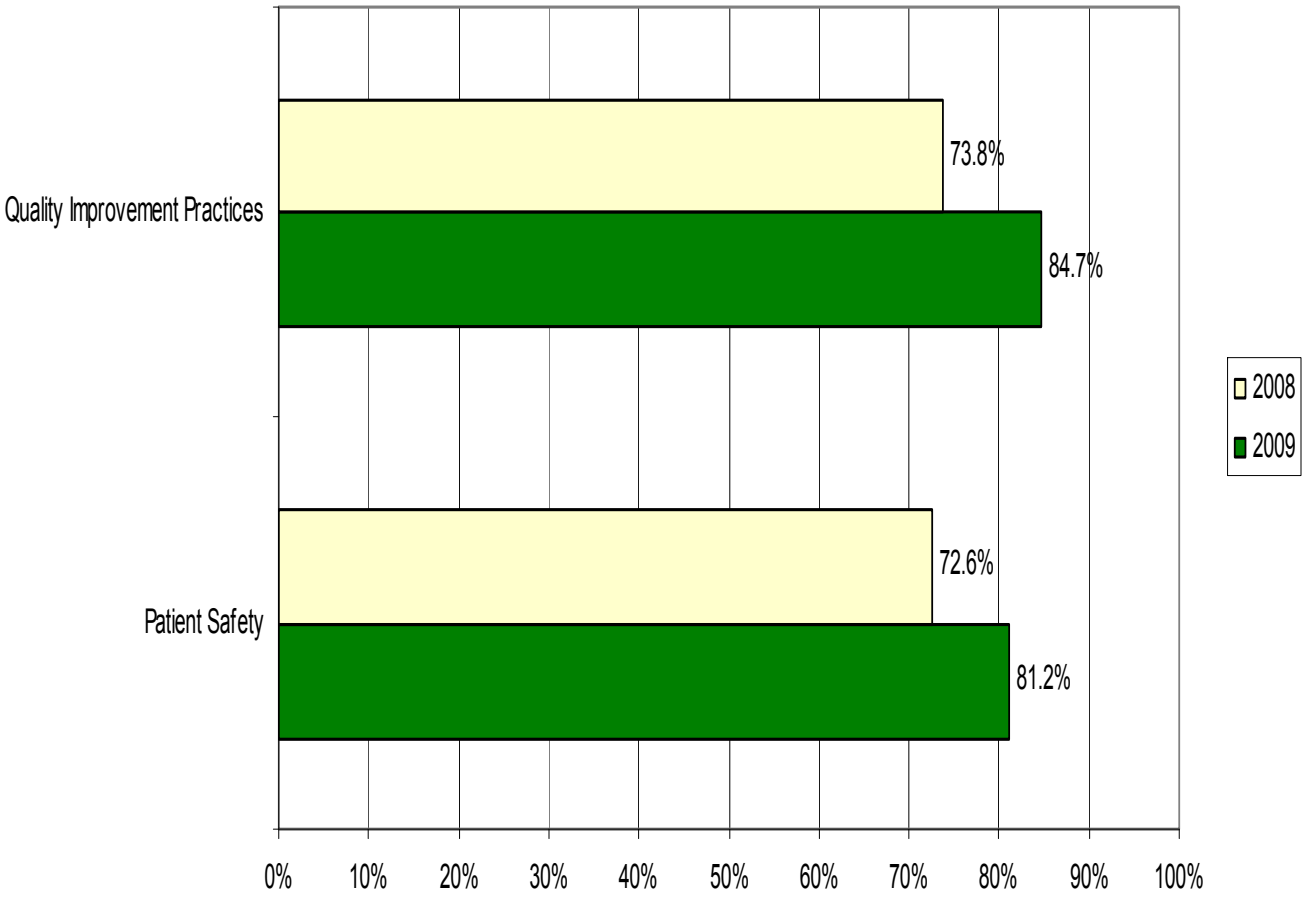
Quality Improvement and Patient Safety

Year over Year comparison



80% – 100 %	World Class
60% - 80%	High Performance
40% - 60%	Some Opportunities
20% - 40%	Needs Improvement
0% - 20%	Immediate Attention

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Nursing Staff Survey: Orthopaedic Unit

1. You are more confident in caring for your patients
2. You have improved communication with physicians
3. You have improved communication with co-workers
4. Your ability to prioritize care has improved
5. Your relationship and rapport with your patients has improved

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'All it takes is one near-miss and the nurses are sold'
Trillium Health Centre introduces nurse-to-nurse report at patient bedside

At Trillium Health Centre, nurses are beginning to engage in more detailed conversation at the bedside during shift changes in an effort to improve patient safety and reduce risk for error at the Mississauga hospital.
It has been well-documented through research that communication breakdown is a major contributor to medical errors and shift change is one point in time where mistakes can happen.

Recognizing this, Trillium Health Centre has launched a new initiative in its orthopaedic in-patient surgical unit aimed at reducing the gap for error. After about 18 months of research, planning and education, the hospital is set to introduce nurse-to-nurse reporting during shift change at the patient bedside.

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Lessons Learned

- Importance of leveraging recent occurrences to support need for change
- Manager, Clinical Educator and Clinical Leader are key change drivers
- Importance of role play
- Importance of supporting documents (TOA literature, standardized template, TOA education plan/vision document and the patient education brochure)
- Importance of standardization of content and process
- Importance of plan, do, study, act methodology

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Keep a Positive Focus

- Involving team in a grassroots change is empowering
- Reinforce the benefits of the change and risks of not implementing
- Convey meaning to the improvement

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Steps to Success

1. Create your team that is focused on supporting a safety culture
2. Develop your TOA template as a team
3. Obtain leadership support
4. Baseline and post implementation data
5. Education and target date
6. Ongoing discussions and audits
7. Maintain a focus for continued improvement

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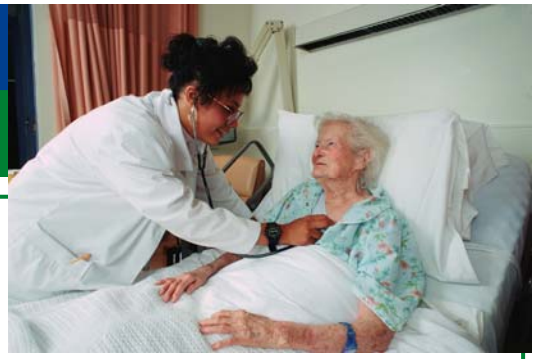
Summary



- We can’t rely on memory alone
- Our communication techniques are imperfect
- Using a resources such as a template for TOA can improve safety and satisfaction

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THANK YOU

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