

HRET HIIN CASE STUDY

QUEST FOR EXCELLENCE

PATIENT WARM HANDOFFS: ED TO INPATIENT NURSING HANDOFF OF CARE

Presbyterian Hospital
Albuquerque, NM



SETTING THE STAGE

Describe how this project is consistent with your strategic plan and how leadership guided and sustained performance expectations.

- > Effective communication during handoffs of care meets Presbyterian's quality plan aim of providing care that is safe and strategic goals of creating exceptional experience for our patients and creating the best place to work for our nursing staff.
- > The Presbyterian Hospital (PH) Chief Nursing Officer (CNO) was the champion for this important safety work. She assisted in removing barriers and supported the culture change needed to effectively implement the project. Sustainment efforts have been championed by the CNO and nursing process owners in the inpatient and emergency departments (ED) to ensure continued process improvement of handoffs and patient experience during this transfer of care.

Why did you select this project and what methods were used to identify the need?

- > There was no standardized transfer hand-off communication between the ED and other units. Staff nurses came forward with concerns including safety events such as delay in treatment, omission of care, and medication errors. The Joint Commission Centers for Transforming Healthcare's Targeted Solution Tool (TST) showed the U.S. rate for defective handoffs is 12%.
- > The information provided by nursing staff and national rates led to identify this work as a priority.

PROJECT DESIGN

Who was involved in the improvement effort?

- > The Patient Handoff team consisted of nurse managers and staff nurses from Adult Medicine units, Cardiac units, Children's, Women's, and the ED. Quality provided facilitation and guidance during planning and implementation

What methodology was used?

- > A combination of six sigma methodology and team communication was used.

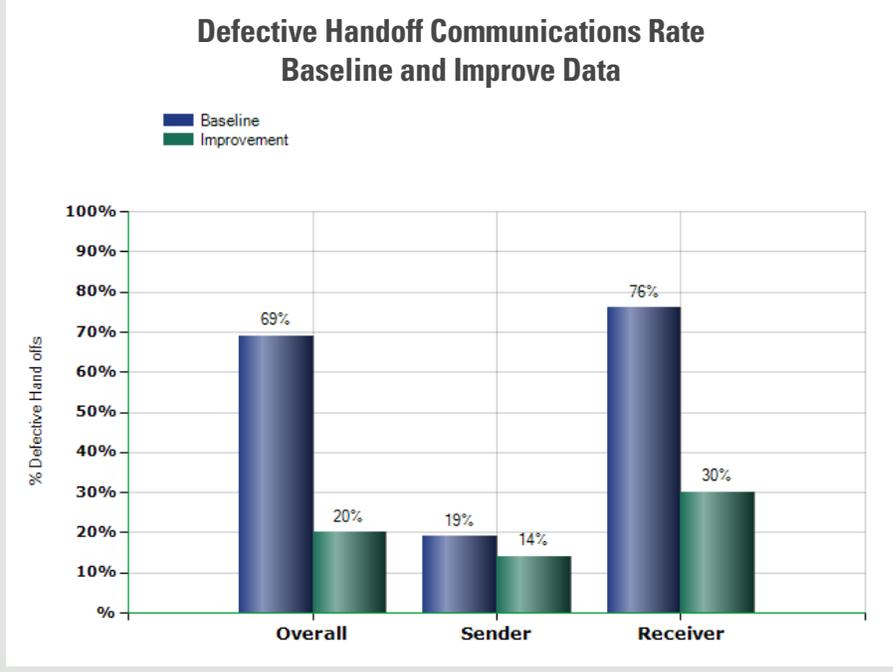
How was the data collected and used to guide your process improvement efforts?

- > July –September 2017: Implemented pre-deployment data collection through use of the TJC TST for handoff communication. The findings (reported by both the sender and receiver) were 69% of handoff communication was considered defective and the biggest opportunities identified were not receiving report, ineffective method, and inaccurate /incomplete information.
- > October 20, 2017: With this baseline data, the team decided that a Rapid Improvement Event using Six Sigma methodology would be planned. The objectives during this time were to develop a standardized tool to continue safely caring for a patient and develop a process from the time the bed is assigned in the ED until patient arrives on inpatient unit.

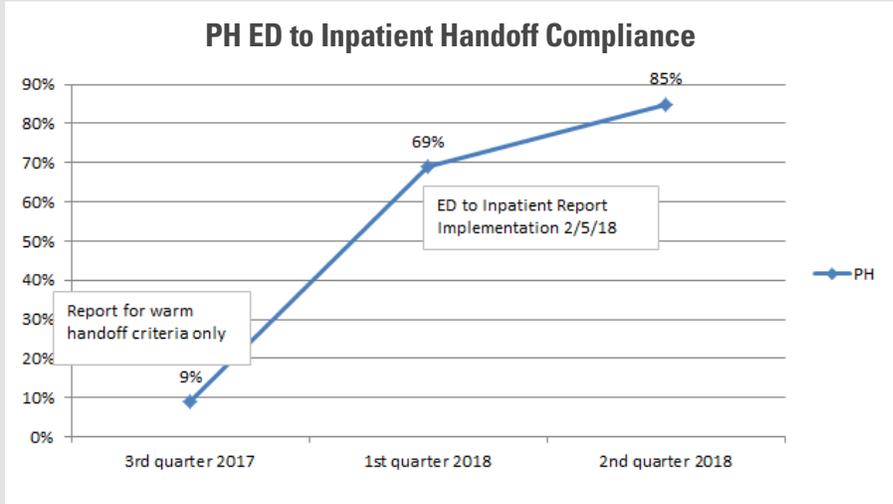
RESULTS

Describe the results including patient outcomes, process changes and service delivery results.

- > The TST handoff tool was completed post-implementation by the IP RNs and ED RNs. The result was a significant improvement from 69% of handoff being identified as defective to 20% of handoffs being defective.
- > Nurses reported not only receiving report but receiving a quality report that allowed them to care for the patient on arrival to the unit.



- > Handoff documentation compliance was another process metric used to measure success. Pre-implementation only 9% of handoffs were documented/completed. At the end of first quarter 2018, we saw an increase to 69% and by the end of second quarter, we saw the rate increase to 85% – an increase of 76%.



LESSONS LEARNED

Warm handoffs are a part of the standard transfer of care at PH. Our team identified some important factors that contribute to our ongoing success:

- > Agreement on what information will be sufficient and with a standardized template, not forgetting the human factor of making a connection with the receiver.
- > Leadership champions are essential as well as involvement by staff nurses from all areas.
- > Continued data and staff feedback on process is essential to maintain progress in the right direction
- > Always see the process through the patient and family's eyes.
- > Understanding of the bed assignment process and how that affects the ED RNs ability to give report is important.

SPREAD AND SUSTAINABILITY

The sustainment phase of our work includes a Handoff and Communications Committee that is comprised of leadership, staff nurses, and bed management staff. This committee identifies any issues and works together to implement new processes or remove barriers.