### Background, Observations & Proposal

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<td>1.</td>
<td>Improve handover communication (by 50%) during single patient transfers from ED to an inpatient ward @ KGH, from the perspective of the nurse receiving. (Pre/post survey)</td>
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<td>Reduce the time interval (by 50%) between the point when the ED is ready to transfer a patient &amp; receiving unit is prepared to accept the patient.</td>
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Clinical handover communication – working toward an IH standard

Handover communication is ubiquitous in healthcare. All clinicians do this (sometimes several times a ‘shift’) yet it is exceedingly rare that this skill is even taught or evaluated in any of the health professions, much less evaluated (in situ) in multi-disciplinary care settings.” Hill 2010

Transfer of accountability (Handoff) occurs at four key points:

1. **Change in Level of Care**
   a. Inpatient admission from the ED or ambulatory care clinic or community
   b. From ICU to acute care or Acute care to ICU
   c. From a Clinic to the ED

2. **Temporary Transfer of Care**
   a. From an inpatient ward or ED to diagnostic imaging, lab, echo/ cath lab and back

3. **Discharge (Transitions)**
   a. Communication to the next care provider (if known) from inpatient unit (phone, letter, discharge summary)
   b. Communication to the home health care provider(s)
   c. Communication to the receiving facility

4. **Change in Provider or Service**
   a. RN/LPN/RRT at Change of shift report (CoSR)
   b. Physician / resident signout
   c. Physician / resident rotation change

Over 2000 reported adverse events from 2010-2012 within Interior Health (IH) are coded by reporters as associated to communication gaps, where reporters answer yes or no to the question: Was handover a factor? (BC-PSLS reporter e-form 2012). Communication gaps in healthcare are associated with > 80 % of adverse events. (JCAHO) **Note: This is roughly where aviation was thirty years ago in 1980, see CRM.**

Handover communication is a ubiquitous problem. A recent quality improvement study (Hill 2011) in IH involved direct observation of frontline clinicians during change of shift report across IH of 26 interactions on 20 inpatient units from 11 hospitals using cognitive human factors methods. This study, including both nurses and hospital physicians found that there were; No formalized handover processes and no explicit expectations for handovers. Of the 26 interactions there were only 4 interactions (15%), which demonstrated effective communication at handover, defined as;

1. face to face communication,
2. use of minimum datasets,
3. opportunity to ask and answer questions,
4. discussion of intention going forward and
5. *use of anticipatory questions by the receiver. Parke & Miskin 2005 /*Hill 2010

Most clinicians are not explicitly trained how to synthesize and prioritize complex information under time constraint. Much of the limited handoff communication work in our health authority has focused on the local creation of increasingly detailed transfer forms (information transmission sometimes by fax only), however we have largely ignored the importance of the interaction and the art of balancing brevity with relevant information for the receiver. This behavior can and must be trained.
Let’s not confuse [fax] data transmission as communication...

The word communication is derived from the Latin "communis", meaning to share. The communication process is complete once the receiver has understood the message of the sender. “Face to face or direct verbal interaction improves situational awareness, and electronic tools are no panacea”. (Woods, D.D., Sarter, N.B. 2010)

The study of healthcare communication at patient handoff is complex due in part to;

i) **Experience**: Differing experience and expertise of clinicians (Senior vs. Junior)

ii) **Exposure**: On a clinician’s first shift he or she will need more time to get to know his new patients, whereas on his or her fourth shift, he or she may know them quite well.

iii) **Time constraint**: Most nurses in BC do not have a scheduled (paid) shift overlap forcing this complex task to be done under severe time constraint.

The **standardization** of handoff communication may not be the goal, rather the mass customization of fundamental handoff principles such as; i) basic communication skills, ii) Standard procedures, iii) Knowing what to handover, iv) being alert to vulnerable patients, v) awareness of responsibility, may be more helpful for large scale improvement.

“The idea of completely standardized handover training is not in line with the identified differences in preferences and recommendations between different handover clinicians. Mass customization of training, in which generic training is adapted to local or individual needs, presents a promising solution to address general and specific needs, while containing the financial and time costs of designing and delivering handover training”. (Kicken 2012)
Toward an IH standard on Clinical Handover Communication

The proposed simple mnemonic to improve verbal handovers (IDRAW) blends the latest evidence from high reliability and resilience science. (Hill 2012). Based on two pilot projects (KGH / VJH), we will be creating a draft IH standard policy for handover and transfer of accountability. There is also a BC-PSQC funded UBC-O/UVIC research study on this topic. We intend to show that clinicians can be quickly and easily trained how to synthesize and prioritize complex information under time constraint. These two verbal templates are:

1. Forward focused
2. Allow for a concise synthesis from the receivers’ perspective
3. Allow for anticipatory planning modeled in practice
4. Even a brief face : face report (< 1 min/pt) can be valuable IF structured and focused forward.
5. Use a template for anticipatory verbal report using the IDRAW acronym

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<tr>
<th>SBAR – Urgent communication</th>
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<tr>
<td>Verbally communicate and agree on actions.</td>
<td>Verbally communicate and ask questions</td>
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<tr>
<td>S - Situation (What is the problem ?)</td>
<td>I – Identify patient (2 identifiers) and MRP</td>
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<tr>
<td>B - Background (Brief relevant history)</td>
<td>D – Diagnosis / Problems (Sick – Not Sick ?)</td>
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<tr>
<td>A - My assessments (Vitals / other issues)</td>
<td>R – Recent changes in last few hours / days</td>
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<td>R - Recommendation (What do we need to do ?)</td>
<td>A – Anticipated changes</td>
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<td>W – What to watch for</td>
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Fundamentals for **Interactive Handover Communication** (based on CRM)

1. Face to face interaction is the ideal
2. Verbal interaction (by telephone) if face to face if not possible
3. Template the conversation (IDRAW /SBAR) so that it’s format is predictable and standardized
4. Reduce the number of intermediaries
   a) PCC links RN/LPN sending to RN/LPN receiving and coaches
   b) RN / LPN trains porters to use “Ticket to ride” See Appendices

**Clinical culture and communication within KGH ED**

An external review of the KGH ED was conducted recently and it’s report is due soon. This external review was preceded by a detailed internal (IH) review by Thora Barnes of the IH Emergency & Trauma Network. Thora’s internal observational review in KGH’s ED describes many opportunities to improve:

**ED nurses feedback**

i) inter-professional working relationships,
ii) timeliness in physicians signing off patients,
iii) patient acuity (CTAS) and safety in the streaming area,
iv) patient movements throughout ED,
v) Shift handover communication (nurses/ doctors/ nurses-doctors),
vi) The inappropriate use of ED in place of GP services especially on weekends.

**ED Physicians feedback**

i) Moral of nurses / doctors/ whole team,
ii) Use of streaming area (keep waiting patients moving),
iii) Admitted patients in both streaming & minor treatment,
iv) Having input into ED candidate selection process,
v) Triage (perhaps Physician triage),
vi) Planning for patient ED revisits (chart prep),
vi) ED Physician participation in hospital flow & overcapacity work.

KGH ED Review (T. Barnes, November 2012)

Since that review WH conducted direct observations of PCC’s and frontline nursing practice in the KGH ED to try to understand opportunities to improve handover communication (and culture) both within the ED and during patient transitions. This data reinforces findings from across IH in 2011 on handover communication.
**0730-0830 Charge RN to PCC Report on multiple patients in multiple areas in ED**

The Charge RN to PCC (seated) report in the ED – PCC office demonstrated 4/5 of the key features of expert communication including:

i) face to face interaction, ii) opportunity to ask and answer questions, iii) use of minimum data sets, iv) discussion of intention going forward and v) use on anticipatory questions.  (Parke & Mishkin 2005 / *Hill 2010*)

The joint focus of attention (Frankel 2012) was also noted.

The PCC & Charge nurses were communicating to the PCC in roughly in the same order as IDRAW

I – Identify patient (2 identifiers) and MRP  
D – Diagnosis / Problems (Sick – Not Sick ?)  
R – Recent changes in last few hours / days  
A – Anticipated changes  
W – What to watch for

This group (PCCs/ Charge RNs) are the logical group to train (as trainers) in CRM and effective handover communication

**Leadership of fundamental nursing practice in the ED**

*The excellent handover skills demonstrated in Charge RN – PCC report did not translate to the bedside.*

Wrae: One patient transfer communication effort I witnessed in ED was particularly poor. A nurse working in ED streaming (K) came into ED main area, (where the PCC was sitting) with a chart held up like a pizza box, saying: “I’ve got a patient for you, post MI, resolving chest pain but needs a heparin drip... where do you want him ??” Receiving nurse in ED Main (L), standing behind the seated PCC said: “Bed 10 please, I’ll be right there”. Thinking I’d have an opportunity to hear handover, I stood by bed 10. The sending nurse (K) brought the patient into bed 10 and left without speaking to the receiving nurse (L) at all. I asked the receiving nurse if this was normal, and she began a 10 minute conversation about how exasperated she was with the lack of patient safety standards...

A general theme I saw from my limited time in ED was that nurses with recent experience in other hospitals and in other provinces / countries were shocked at the lack of fundamental patient safety systems in place such as; handover standards, MAR double check by pharmacist and falls precautions, whereas even experienced nurses [who had always worked at KGH] seemed less concerned or perhaps less aware. All seemed very concerned about the workplace culture and the overarching issue of admitted patients in the ED creating “KGH’s biggest inpatient ward, now within the ED.”
**KGH Bed Meeting / Staffing and Patient Flow Observations Dec 20-29**

The weekday KGH bed meeting (0930 – 1000 hrs) is well attended by all patient care coordinators (PCCs), Transition nurses, several unit managers as well as several KGH Directors. Much improved from just a year ago, the utilization coordinator initially leads the meeting and revises a pre-populated spreadsheet which calculates the % occupancy rate and illustrates patient flow within the hospital. The key decisions (arbitrations) seem to be left to the Director(s) to make. By contrast, the weekend bed meeting was attended with only a few PCCs and is chaired by the UCMN (Utilization and Clinical Management Nurse) who is the highest ranking clinical leader on staff on weekends. On the weekend day I attended there were 25 sick calls on days (Sat Dec 29th). Clearly, matching clinical workload to available clinical staffing is an ongoing system challenge.

**Observations**

1) **Clarity of expectations**: PCCs provide a report which might be better targeted to the task at hand (patient movement and discharge decisions). There is no accepted standard KGH template for this report out, except by verbal coaching.

2) **Acuity Score**: Patients are not ranked by acuity, so it is hard to know how to match workload with available staffing skills. This creates negotiations at every meeting about which patient is most appropriate for which unit.

3) **Hospitalists**: Physicians (eg: Hospitalists) do not attend the bed meetings. The 5-6 hospitalists on weekday shift receive their physician to physician report at ~ 0830-0930 in another part of the hospital, and care for ~ 70% of inpatients. The link between this meeting and the hospitalists is a KGH Director.

4) **Afternoon feedback**: There is no afternoon update meeting except in emergencies (See Vancouver example pg. 5)

5) **Deal closure**: Patient movement decisions seem to be deferred to the director to “close the deal”.

**Suggestions to improve communication at the KGH bed meeting**

1) **Create a single page report template for all PCCs to bring to the daily bed meeting** (Appendix 2)
   a. All admitted patients in ED should each have an inpatient transfer summary completed (and updated if transfer is delayed) using the IDRAW format. This form includes contact information and an invitation to call the ED nurse when ready to accept.
   b. This should be completed by the bedside ED nurse on nights to give to the Charge RN /PCC on days. Included is an acuity score (1-3) , Potential inpatient (ward) destination

2) **Ask a Hospitalist to attend and provide feedback on the meeting’s efficiency & utility**. This is crucial because the Hospitalist is likely to have knowledge of which GPs are covering or on call. Systems problems at KGH are symptomatic of upstream (GP/Community) and downstream (Hospital/Discharge) system restraints such as: i) admitted patients in ED, ii) GPs sending patients to ED for follow up, iii) Use of the ED as a clinic. Physician participation is crucial.

3) **Hold a short (15 min) afternoon debrief of affected inpatient units and the ED PCC**  On one day I observed this, 45 patients (50% greater than normal) were moved out of ED. This is good news which should be shared w/ frontline staff.
These problems are not unique to KGH. The learning from the Western ED Overcrowding Conference, held on April 21-22, 2012, showed that Vancouver General Hospital had done the following to enable better communication, access and flow:

- Established clear plans and directions for the day with bed meetings.
- Med/Surg ownership of admitted ED patients.
- Senior Leadership visibility is key... go to where the work is. Look, listen, feel and ask questions every day.
- Solve problems together and take risks together.
- COO and Senior Leaders engaged at all levels within the organization.
- Support ED staff to do the work they need to do, allow the ED to do ED work, not inpatient work.
- Focus on patient outcomes/quality/safety in the forefront.
- Leadership accountability.
- 2 daily “bed” meetings, directors and managers.
- Establish standard organization response when ED volumes have increased - taking patients in off service beds to increase movement. (Overcapacity protocol)
☐ Invest in areas to support the organization. Physicians/porters/housekeeping/ floating unit clerks.
☐ Reinvest across the continuum (i.e., Community Care).
☐ Meet weekly around long LOS patients. Include ED in this process.
☐ Focus on the readmission rate and why are they coming back in where to reinvest.
☐ Patient discharges on weekends. Community plans ahead for weekend discharges.
☐ Psych Liaison Nurse is part of the daily meetings.
☐ Social Worker is part of the daily meetings to deal with social admissions.

KGH ED Review p.26 (T. Barnes, November 2012)

In addition, an expected date of discharge is important to include up front (KGH Med QI meeting Dec 2012). This work is closely aligned with the Transitions work of the Central Okanagan Divisions of Family Practice (CODFP) to address transition communication between GPs, ERPs and Hospitalists.

(CODFP Dec 2012)

On December 19, 2012 the Joint Commission R³ Report explained that Patient Flow through the Emergency department as a Hospital-wide Concern. The report updated Leadership standards that emphasize the importance of patient flow in hospitals. The revised standards make clear that the flow of patients must be managed systematically throughout the entire hospital. The JCAHO standards were revised and developed to enhance patient safety by addressing:

1) Data and metrics to better manage patient flow as a hospital-wide concern;

2) Safe provision of care for patients should boarding occur,

3) Mitigating risks experienced psychiatric emergency patients boarded in the ED.

http://www.jointcommission.org/joint_commission_report_explains_revised_patient_flow_requirements/
Crew Resource Management for Healthcare

Understanding the concept of CRM as a safety system begins with understanding the history of aviation mishaps. The dismal record of modern air disasters sheds light on the birth of CRM. Aviation’s worst disaster ever, a collision between two jumbo jets in 1977, provided the strongest catalyst for airlines to develop a “different way of doing things” that ultimately became CRM.

**Tenerife 1977 Crash of two B-747 aircraft**

The key to better safety and fewer accidents is managing the inevitable error. Aviation and other high-reliability organizations now manage (as healthcare is beginning to) these inevitable errors by doing two things:

1. Training teams to use specific teamwork and communication behaviors. **(A crucial step often missed)**

2. Implementing safety tools (e.g., procedures, protocols, checklists, etc.) that complement those behaviors to detect and trap small errors before they become serious or even fatal mistakes.

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CRM, whether used in aviation or healthcare, is a combination of teamwork and communication behaviors, and the safety tools that support those behaviors.
ATC Clearance: “A real-life example of CRM in action occurs every day when a cockpit crew is given a clearance by Air Traffic Control (ATC) to climb to a new altitude.

Pilot Read back: The flight crew will acknowledge the new instructions from ATC and “read back” the exact altitude to which the flight has been cleared. ATC will listen for this read back and, if it is not received, will query the crew as to whether they heard the instruction.

Cross check: Should the crew read back an altitude different from the one given, ATC can immediately intervene and correct the mistake. This cross-check prevents collisions between aircraft. Both parts of the CRM safety system are seen here:

- Precise communication between flight crews and ATC (communication skill)
- The standard operating procedure of providing a read back (safety tool).“

Crew Resource Management (CRM) begins with two key skills;

1. Fatigue management countermeasures
2. Ability to anticipate and recognize weak warning signals (red flags)

Equipped with these two skills, CRM participants learn how to;

3. Rapidly and effectively develop an effective team with diverse skills and technical abilities
4. Communicate effectively, with precision without regard for rank or hierarchy
5. Recognize & immediately communicate red flags (SBAR format)
6. Recognize & mitigate fatigue effects, cross check and back up their own performance
7. Use effective team problem solving skills
8. Provide pre-brief & de-brief performance feedback to each other in non-threatening ways that promote learning and improves performance the next time
Crew Resource Management (CRM) in Healthcare - Results

### CRM in Commercial Aviation

As the CRM system became widespread in aviation, dramatic decreases in accident rates occurred in a variety of related organizations that used CRM as well.

- **Military transport squadrons reduced accidents by 52%**
- **Navy aircraft reduced accidents by 81%**
- **Helicopter accidents declined by 54%**
- **Major U.S. airlines, in 2005 had no passenger fatalities since the fall of 2001—almost four years**

CRM was so effective that it became required in 1992, by the FAA at all U.S. airlines. The military and other government flight organizations quickly followed suit. In fact, all modern high-reliability organizations use some form of CRM to manage human fallibility and achieve safety in otherwise potentially dangerous environments.

### CRM in Healthcare

Effectively implemented CRM programs appearing in peer reviewed journals

- **Surgical count errors reduced 50%** (Rivers 2003)
- **Clinical error rates reduced from 30% to 4.4%** (Morley 2002)
- **Adverse outcomes reduced 53%** (Garza 2004)
- **Observed errors reduced 55%** (ACOG 2005)
- **Teamwork and communication skills, vs. previous surgical experience alone, determine how quickly medical personnel develop expertise with new technology in minimally invasive cardiac surgery.** (Pisano 2001)

### Other observations

- **10-fold reduction in wrong surgeries**
- **Improved pre-procedure antibiotic administration from 68% to 96%**
- **30% reduction in nurse turnover**
- **Statistically significant improvement in employee satisfaction survey responses**

References: CRM in Healthcare as of 2005

**CRM is strongly recommended by leading healthcare organizations**

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the IOM, the Accreditation Council for Graduate Medical Education (ACGME), and others recognize the usefulness of CRM training and safety tools. The Accreditation Council for Graduate Medical Education (ACGME) is the body responsible for accrediting the majority of internships, residencies, and fellowships, aka subspecialty residencies) for MDs in the USA. JCAHO requires hospitals to adopt some of the proven safety tools from ultrasafe organizations.

- In 2003 the JCAHO required that a **time out** be conducted prior to procedures to eliminate wrong surgeries. The time out is similar to the preflight briefing done by all flight crews before each takeoff.

- In 2005, the JCAHO required “**read back**” of verbal orders and other important healthcare information, and in 2006, it requires hospitals to develop a **standardized “handoff”** of patient information when patient care is transferred from one caregiver to another. This is a concept and model adopted from aviation.

For example, when switching from one ATC center to another, pilots and controllers follow a specific protocol designed to prevent errors and ensure precise, continuous control of aircraft.

The ACGME has also adopted some of the basic concepts of CRM by making communication, system based practice, and continuous improvement core competencies that residents must master during their training.

Along with medical knowledge and technical training, young physicians learn that they must communicate, make good decisions, and function as part of a team to reach their highest potential. The IOM identified six dimensions of the ideal healthcare system. It must be safe, effective, patient-centered, timely, efficient, and equitable. It was perhaps no accident that “safe” was listed as the first aim that must be achieved. Without safety, the other dimensions become irrelevant. To achieve patient safety, a coordinated program such as CRM must be put in place.
**Important: CRM is behavior modification, be transparent about this.**

Hospitals and other healthcare facilities wishing to sustain the improvements in behavior and performance resulting from their teamwork training programs must do two things well:

- Embed those teamwork behaviors into their daily work culture; and
- Provide multiple opportunities for staff members to practice the use of those teamwork behaviors.

Additionally, to successfully implement CRM, an organization’s culture needs attention. How do you improve culture?

Here’s the formula used successfully in commercial aviation and in healthcare organizations that have successfully implemented CRM:

**Thoughts + Actions + Habits + Character = Culture**

This formula means that to change culture you must first change the character of the people within the organization. To change character, change individual habits. To change habits, change actions. To change actions, change how people think at the moment of truth in each process.

**To summarize:**

1. To affect **Thought Processes** and **Actions** – conduct effective training;
2. To hardwire **Actions** and make them become **Habits** – implement safety tools like checklists, scripting, protocols, etc.;
3. To nurture and sustain **Habits** to change **Character** – perform Leadership actions;

Change **Thoughts**, Get **Actions**, and Create **Habits** and you will Change **Culture** and sustain performance improvements resulting from your CRM program.
### CRM Sustainability Tips:

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<td>CRM training must be provided to all clinicians and staff involved in providing care.</td>
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<td>2</td>
<td>Conduct periodic refresher training on teamwork skills.</td>
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<td>3</td>
<td>Use data from Direct Observational Study of Teamwork Behaviors.</td>
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<td>4</td>
<td>Conduct new-hire training</td>
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<td>5</td>
<td>Customized, site-specific safety tools (e.g. checklists, communications scripting, standard</td>
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<td>operation procedures, etc.) thoughtfully adapted from HROs, must be created and implemented.</td>
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<td>6</td>
<td>Managers and administrators must “Round” on departments that</td>
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<td>have implemented teamwork training and safety tools.</td>
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<td>Leadership must be willing to conduct coaching conversations with</td>
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<td>low performers and impose consequences for poor performance.</td>
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<td>8</td>
<td>Ensure safety and teamwork become part of the corporate mission</td>
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<td>or annual goals.</td>
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<td>9</td>
<td>Safety and quality metrics must be part of the dashboard used to</td>
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<td>measure performance.</td>
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<td>10</td>
<td>Executive assessment and reward systems must be aligned with</td>
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<td>teamwork-based safety initiatives.</td>
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<td>11</td>
<td>Physicians must be actively recruited as “partners” in support of</td>
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<td>the teamwork-based safety and quality program.</td>
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<td>12</td>
<td>Revise the Policy &amp; Procedures Manual and other unit documents to</td>
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<td>include teamwork and behavioral guidelines.</td>
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<td>13</td>
<td>Institute a system to capture teamwork-based safety program</td>
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<td>successes and publicize those to the organization</td>
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### References

Kelowna General Hospital Proposal:
Conduct Crew Resource Management (CRM) - Team Communication Training in the ED with PCCs / TNs

1 Day - Train the Trainer in CRM, Handover
3 Months – Ongoing team support and coaching to improve handover & transitions

Participants: (Max 36)
Group 1 (Two days) - PCCs / Charge RNs / Transition Nurses (TN)
Group 2 (Half Day) - Hospitalists / MDs in COK Divisions of Family Practice + Group 1

Aims:
1. Improve handover communication (by 50%) during single patient transfers from ED to an inpatient ward @ KGH, from the perspective of the nurse receiving. (Pre/post survey)
2. Reduce the time interval (by 50%) between the point when the ED is ready to transfer a patient & receiving unit is prepared to accept the patient.

Method: Focus group exercise with KGH PCC / Charge RNs plus direct observation on units as desired by PCC leaders

Handover outcomes envisioned: “Train the trainer”
- KGH PCC / Charge RN / RRTs model / demonstrate a willingness to evaluate their own communication practice in a team context.
- KGH PCC / Charge RN / RRTs receive feedback on their own handover practice both as giver and receiver.
- KGH PCC / Charge RN / RRTs demonstrate ability to train others using 2 simple verbal mnemonics to improve urgent & non-urgent handover communication under time constraint.
- Adopt as standard part of in-charge training and next generation clinical leadership

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<td>I – Identify patient (2 identifiers) and MRP</td>
</tr>
<tr>
<td>B - Background (Brief relevant history)</td>
<td>D – Diagnosis / Problems (Sick – Not Sick?)</td>
</tr>
<tr>
<td>A - My assessments (Vitals / other issues)</td>
<td>R – Recent changes in last few hours / days</td>
</tr>
<tr>
<td>R - Recommendation (What do we need to do?)</td>
<td>A – Anticipated changes</td>
</tr>
<tr>
<td></td>
<td>W – What to watch for</td>
</tr>
</tbody>
</table>
Future:
- Create KGH wide minimum standards for four types of verbal clinical handover communication
  i. **Change in level of care**: inpatient admission from the ED, clinic, or procedure area/transfer from ICU to acute care or from acute care to ICU/transfer from a clinic to the ED
  ii. **Temporary transfer of care**: from inpatient, clinic, or ED to OR, procedure area, diagnostic area
  iii. **Discharge communication**: to next care provider (if known) at inpatient discharge (via phone, letter, or discharge summary), communication to Home Health provider, communication to transfer facility (skilled nursing facility, another hospital)
  iv. **Change in provider or change in service**: RN/RT change of shift, resident sign-out, rotation change (housestaff and faculty)

A big issue is actually identifying and then explicitly connecting the nurse who knows the patient best (sender) with the nurse who may ultimately take that accountability (receiver). In many circumstances this is currently done through intermediaries. I suggest that Patient Care Coordinators to find ways to explicitly connect the sending nurse (say in ED) with the nurse who will ultimately take the accountability (receiver) for that patient.


**Coordination role outcomes envisioned:**
- KGH PCC/Charge RNs model / demonstrate a willingness to evaluate their own coordination practice in a cross continuum team context. (egg: My admitted patients in ED are my patients)
- KGH PCC/Charge RNs demonstrate ability to explicitly identify and connect the clinician who knows the patient best (sender) with the clinician(s) who may ultimately take that accountability (receiver).
- Reinforce IDRAW handover tool

Outcomes: Improve consistency of communication transfer at handovers, connecting senders & receivers, as judged by the clinician receiving the patient

**Evaluation:**
References

1) KGH ED Review (T. Barnes, November 2012)
2) Central Okanagan Divisions of Family Practice (CO-DVP) Tristan Smith – personal communication Dec 2012


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**Extras**

House – Puffer (0:33)  [http://www.youtube.com/watch?v=dMAS2S51bM8](http://www.youtube.com/watch?v=dMAS2S51bM8)
Appendix 1- Handover FAQ from Virginia

Handoff of Care
Frequently Asked Questions

What is “handoff of care” communication?
"Handoff of care" communication is a real-time, interactive process of passing patient specific information from one caregiver or team to another for the purpose of ensuring the continuity and safety of the patient's care.

What is the requirement for handoff of care?
Every hospital must implement a standardized approach to "handoff" communications. This includes an institutional definition of when handoff must occur, what elements must be communicated, that handoff must be "verbal" and include an opportunity to ask and respond to questions, and that "like" handoffs are performed in a consistent way.

What are "like" handoffs? Is every handoff the same? Are we being told how to do handoff?
The institution is not being prescriptive about how handoff is done. Units or residency programs may decide how they will do handoff. Handoff may be face-to-face, phoned, taped, or may incorporate information from a computerized data source as long as it occurs at specific points of care and includes the five standard elements. For instance, some nursing units do face-to-face change of shift report; others tape record the report. Some residency programs use computer signout; others do only a face-to-face handoff. Either approach is fine as long as it remains consistent within that unit or program and includes the five elements.

Why is handoff of care important?
Handoff of care is a National Patient Safety Goal developed by the Joint Commission (JCAHO). All JCAHO-accredited hospitals are required to implement these goals. The University of Virginia Health System is committed to implementing the patient safety goals because it is the right thing to do for our patients.

Medical errors are reported to JCAHO from across the nation. Based on those reports, patient safety goals and recommended strategies to meet them are developed using evidence and expert consensus. The national experience mirrors our local experience and confirms that medical errors occur most frequently at times when health care providers communicate clinical information as providers change or as the patient moves across the continuum of care.

Think about all the times during the day when you communicate clinical information to other caregivers...transferring a patient from ICU to acute care, sending a patient for a diagnostic or surgical procedure, giving change of shift or signout report. One recent study shows a 40% increase in resident handoffs since implementation of the "80 hour" rule, with each resident participating in as many as 300 patient handoffs per month. Each transition is a vulnerable point when incorrect information could be conveyed or crucial information omitted.

When must handoff occur?
Handoff of care occurs when responsibility for patient care changes due to a change in patient location or change in provider. These are the four types of handoff:

1. Change in level of care
   - inpatient admission from the ED, clinic, or procedure area
   - transfer from ICU to acute care or from acute care to ICU
   - transfer from a clinic to the ED

2. Temporary transfer of care
   - from inpatient, clinic, or ED to OR, procedure area, diagnostic area

3. Discharge
   - communication to next care provider (if known) at inpatient discharge (via phone, letter, or discharge summary)
   - communication to Home Health provider
   - communication to transfer facility (skilled nursing facility, another hospital)

4. Change in provider or change in service
   - RN / RT change of shift
   - resident signout
   - rotation change (housestaff and faculty)

What kind of information should be included in handoff...or not?
Handoff should give the accepting clinician a snapshot of pertinent information that will enable immediate provision of seamless care. Handoff is not a comprehensive communication of every detail of the patient's history or clinical course. Avoid passing on all possible information in an effort to be comprehensive. Too much data may mask or bury the important nuggets that the next provider needs. Don't list every medication the patient is on. Talk about new medications, those that require monitoring or adjustment, and suggestions for medications that should be ordered if certain clinical events occur. Don't pass on every lab test that is ordered or every lab result, especially historical data, orders, or clinical results that are easily accessible using available electronic resources (CareCast or MIS). Communicate critical test results, planned diagnostic procedures, and the plan of care associated with those results.
Handoff of Care
Frequently Asked Questions

Are there standard elements that are required in each handoff communication?
Yes. These are the standard elements that, at a minimum, are required in each IDEAL handoff communication:

- **Identify**: Patient name and medical record number or date of birth; and physician name
- **Diagnosis**: Diagnosis and current condition
- **Events**: Recent events / changes in condition or treatment
- **Anticipated**: Anticipated changes in condition or treatment, what to watch for in next interval of care, contingency plans
- **Leave**: Leave time for the opportunity to ask questions and clarify information

Is verbal handoff mandatory?
Verbal handoff is required for all clinicians who provide continuous, 24/7 services (housestaff and other licensed independent practitioners, nurses, respiratory therapists). Verbal report may be face-to-face, phoned, or taped, and may incorporate computer-based information. When handoff is not face-to-face, the sender/off-going clinician must be available to answer questions and clarify information for the receiver/on-coming clinician. Many nursing units tape report for the oncoming shift. This is acceptable as long as the off-going nurse is physically available for questions after the oncoming nurse has listened to report. Relying on the option to call a nurse from the previous shift at home is not acceptable because there may be a reluctance to do this. Direct care providers who do not provide 24/7 services (e.g., physical therapy) may provide a written handoff progress note that includes at least the five standard elements and contact information (phone/PI) where the receiver may obtain information or clarification.

Is handoff of care documented?
There is no requirement to document handoff at change of provider (nursing shift change or resident signout). Documentation is required when there is a transfer in level of care, a temporary transfer in care, and at discharge.

What tools will assist me to document handoff?
1. The **MIS HOC Report** is used for temporary or permanent inpatient transfers, including the patient being admitted from the E.D. The report populates patient demographics and diagnosis from existing MIS fields. The nurse prints the report from the MIS PT PRINTOUT menu, writes recent and anticipated changes, signs the report, uses the document as a template for giving verbal report, and sends the report with the patient. There is an opportunity for any discipline to write information on the report.
2. The **Ambulatory HOC Report** (available from UVA Printing Services) is used for temporary or permanent transfer of ambulatory patients to or from a clinic or diagnostic/procedure area and when an E.D. patient is transferred to and from a diagnostic/procedure area.
3. Housestaff should always use the **MIS ORDER TRANSFER** and **ACCEPT TRANSFER** pathways to document order review and reconciliation.

Why is it important to use the Patient Profile section of the MIS HOC Report?
A Patient Profile is required for the MIS HOC Report. Many inpatient areas rely on the Profile to standardize patient information for shift report as well as other communication needs. If your area does not currently use the Patient Profile, consider how this information can be integrated into your practice and communication strategies, and adapt your practice to populate the Profile upon admission and update it as needed.

Have the requirements for writing a transfer note changed?
The MIS HOC Report replaces the Nursing Transfer Note for transfer of inpatients between units. A comprehensive physician transfer note is still required when the patient changes level of care at and service rotation.

Will the HOC Report become part of the permanent medical record?
Both the MIS HOC Report and the Ambulatory HOC Report should be placed in the Progress Notes section of the patient’s chart after completed. Health Information Services will scan both reports into the permanent medical record after the patient is discharged.

Is handoff communication required when a patient moves from an inpatient unit to radiology or other diagnostic testing area?
Yes. The information communicated may be limited to what is relevant to the procedure, but it is a handoff and should follow a standardized procedure. This alerts staff in the testing area that the patient is there and provides an opportunity to properly identify the patient and test to be done. Change in requirement: A MIS HOC Report should be sent with all inpatients who travel to radiology, whether for a “simple” diagnostic test (ex. plain x-ray film) or a complex procedure (ex. interventional radiology, endoscopy). Verbal handoff is optional, based upon nursing judgment. Staff in the diagnostic area add information, sign the same HOC Report, and send it with the patient back to the home unit.
How do I hand off a patient who will be transported by a non-clinical transporter?
When a temporary or permanent patient transfer that requires handoff is completed by a non-clinician transporter, the sending clinician gives the written HOC Report to the transporter who delivers it to the receiving staff. The receiver must have the opportunity to ask questions and clarify information.

Could handoff requirements differ between disciplines in a single patient handoff?
Yes. Handoff is not required when the responsible clinician will not change. Example: When an ICU patient is transferred to another ICU as a boarder, and the medical service will not change, physician handoff is not required, but nursing handoff is required.

Are there times when a patient is transferred that handoff is not required?
Yes. Handoff is not necessary during a temporary transfer when a patient will be continuously accompanied by a clinician from the sending area. For example, when an ICU patient is accompanied to interventional radiology by an ICU nurse who will be in continuous attendance with the patient until the patient returns to the home unit, nursing handoff is not required.

When is physician-to-physician handoff done for a patient admitted from E.D., clinic or O.R.?
For an E.D. admission, physician handoff occurs when the admitting team sees and examines the patient in the E.D. If the same physician will accept the patient on the inpatient unit, then no further handoff communication is required. Handoff occurs at the point when responsibility for the patient’s care changes. The same applies to physician handoff for a patient being transferred from a clinic or the OR; if the same physician has responsibility for the patient in both locations, then no handoff occurs. However, the physician must communicate to the nursing unit or to any ‘covering’ physician who assumes temporary care of the patient until the admitting physician arrives.

Can I use the same MIS HOC Report if the patient will be traveling to several locations over the course of my shift?
The patient’s condition may change over time, making the information on a previous MIS Report outdated. Print a new MIS HOC Report for each temporary transfer from the unit. Exception: The patient who travels from location to location without returning to the home unit.

Do I send a MIS HOC Report with the patient being transferred to a nursing home?
No. The MIS Home Health Referral and the physician’s Discharge Summary are all that is required.

If a clinic patient is referred to the E.D., do I need to send an Ambulatory HOC Report?
Clinic patients may be sent to the E.D. via ambulance or may be advised to travel by private vehicle. In either case, a phone call should be placed to the E.D. If the patient travels by ambulance, the Ambulatory HOC Report is given to the ambulance personnel for delivery to the E.D. If the patient travels by private vehicle, the Report should be faxed to the E.D.
“A Ticket to Ride” protects patients off the unit

By Leslie N. Ray, RN, PhD

“A Ticket to Ride” protects patients off the unit

JOHN GREEN, 45, hospitalized with abdominal pain, has a history of anaphylaxis to latex. His nurses identified his latex allergy, placed an allergy band on his wrist to alert healthcare providers, and instituted latex precautions to prevent contact with latex-containing materials. Two days into his hospital stay, Mr. Green was sent to another department for a diagnostic study. Staff in this department, having no clinical information about the patient other than his possible diagnosis and his scheduled procedure, performed the study using vials and syringes containing latex.

Mr. Green experienced latex-induced anaphylaxis, requiring aggressive support of airway, oxygenation, ventilation, and circulation.

This hypothetical case, based on an incident reported by the Institute for Safe Medication Practices, clearly demonstrates why patient information must be accurately conveyed at all stages in a patient’s care. Gaps and inaccuracies in shared information frequently contribute to potentially serious adverse events.

The Joint Commission (TJC) and the National Quality Forum endorse giving appropriate, timely, and accurate information to all healthcare providers and facilities involved in a patient’s care. To prevent communication breakdowns, structured handoffs are an essential safeguard as outlined in National Patient Safety Goal 02.03.01. This article describes a concise handoff tool, the Ticket to Ride, which helps maintain patient safety and continuity of care when patients temporarily leave their unit. (See Do you have a Ticket to Ride?)

What’s a handoff?

A handoff or handover is the transfer of responsibility for care from one healthcare professional to another. Longer term handoffs include those between physicians when on-call status changes. Temporary handoffs include nursing coverage for patients when their nurse is away from the unit.

DO YOU HAVE A TICKET TO RIDE?

NAME: ___________________ DATE: ___________
DESTINATION: ___________________ TIME: ___________
Unit: ___________________ RN: ___________ Phone #: ___________

Allergies: □ NKA Yes:

Fall Risk: □ Yes Assistance □ Close observation □

Hearing: □ N/A Hearing aid □ Right / Left / Both
Vision: □ N/A Blind □ Glasses □ Contacts □

Medications: insulin □ last dose ___________
pain □ last dose ___________
sedation □ last dose ___________
anticoagulant □

Other Needs: O2 □ nasal cannula □ mask □ E-T tube □ trach
Position □ supine □ seated □ other □
Keep HtB at □ 30° □ 45° □ 90°

Monitoring: □ SpO2 □ Cardiac rhythm □ BP
□ IV pump(s) □ Rate @ ___________

RETURN STATUS:
□ Unchanged □ Changes in status (Describe) ___________
□ Unit staff notified □ Oxygen resumed □ Cardiac monitor resumed
Transporter (Print Name) ___________

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