



Transfer of Accountability

Advancing *Patient Safety* Through Shift-to-Shift Communication *Standards*



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Presentation Outline

- Background
- TOA Project
- Strategies & Tools
- Lessons Learnt
- Good News





Background

Hamilton Health Sciences

- 5 Hospitals + Cancer Centre
- Over 1000 beds and 24 bassinets
- Largest employer in Hamilton with nearly 10,000 employees





The Problem

Communication problems cited in 60% of sentinel events reported to JCAHO.

(JCAHO. Sentinel event Statistics: <http://www.jcaho.org>)



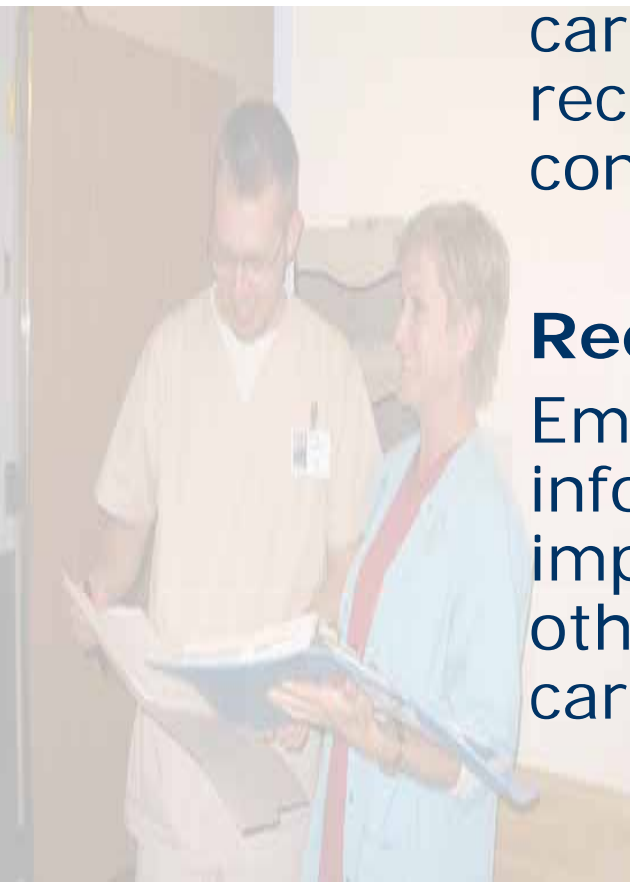


CCHSA Patient Safety Goal

Goal 2: Improve the effectiveness and coordination of communication among care/service providers and with the recipients of care/service across the continuum.

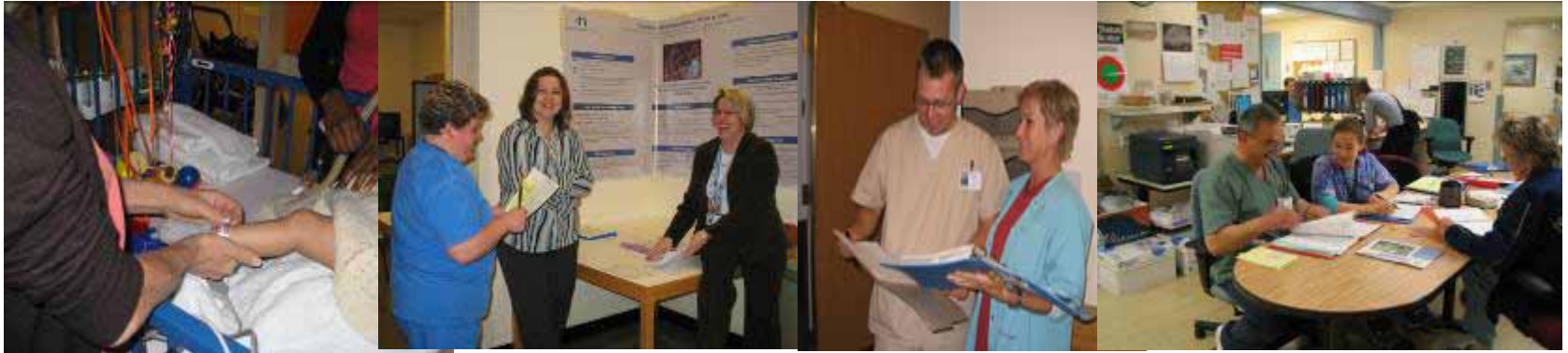
Required Organizational Practice:

Employ mechanisms for transfer of information at interface points; implement verification processes and other checking systems for high risk care/service activities



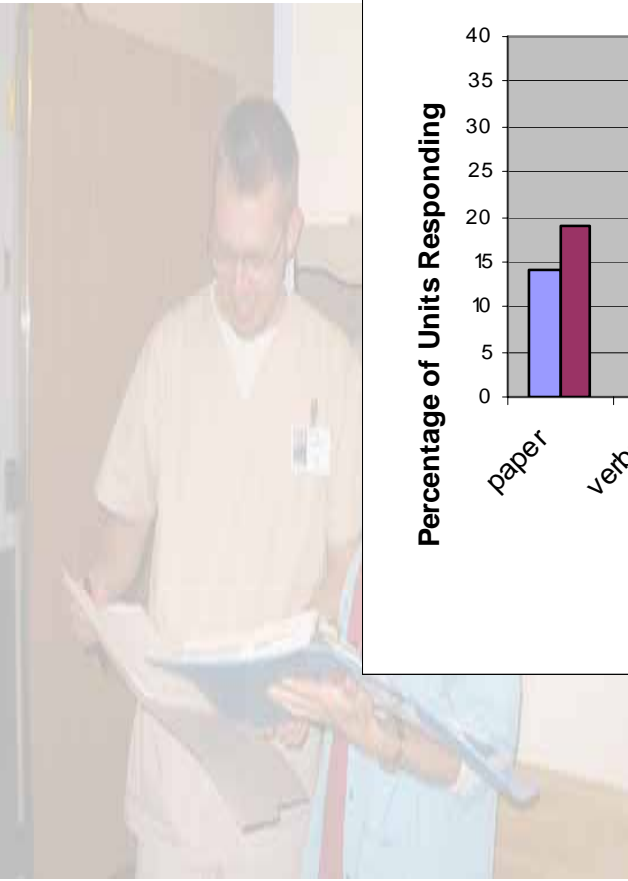
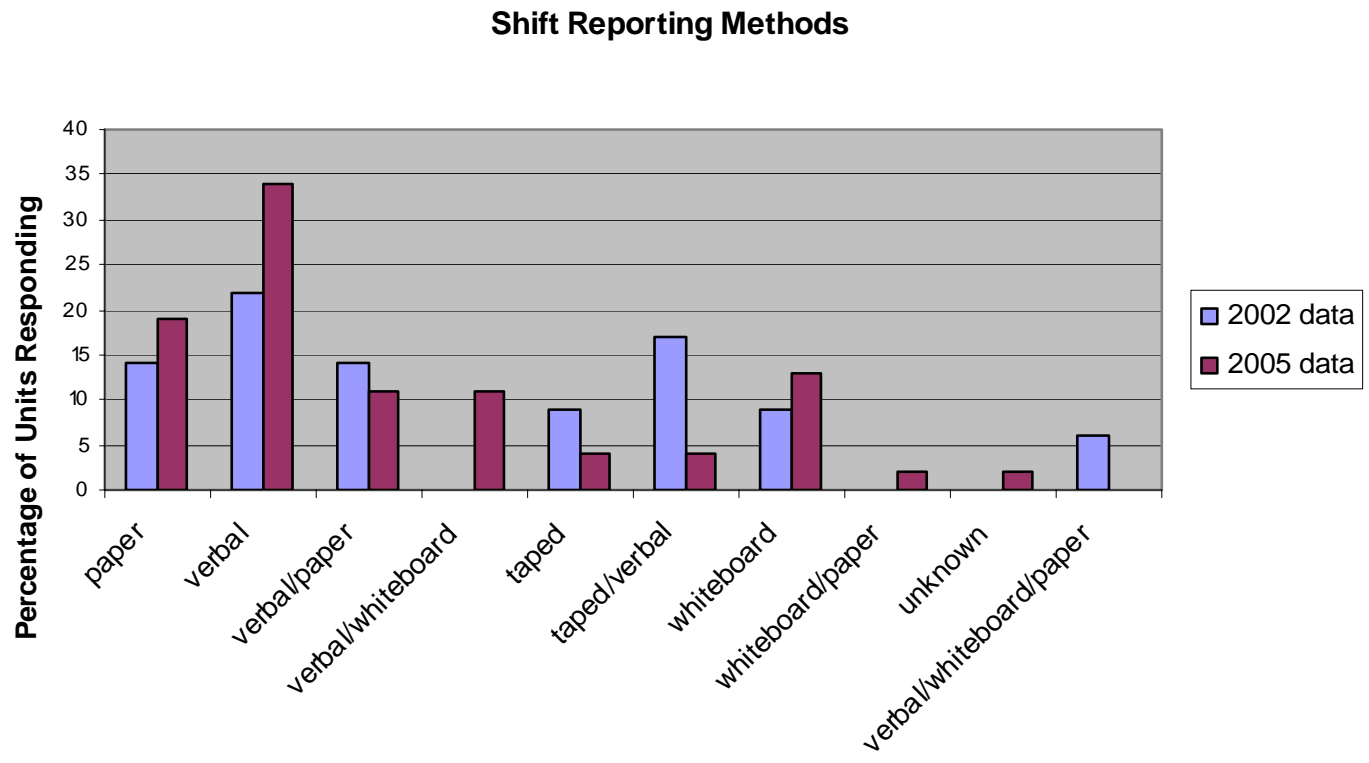


Corporate Initiative 2005





Assessment of Practice





Guiding Principles

- Important to complete bedside patient safety checklist
- Nurses have to talk to each other-face to face report. Have a chance to clarify and ask questions
- Team leader or charge nurse should have the total unit picture with a written report from shift to shift
- Decrease reliance on memory-have a written tool





Five Step Plan for Implementation

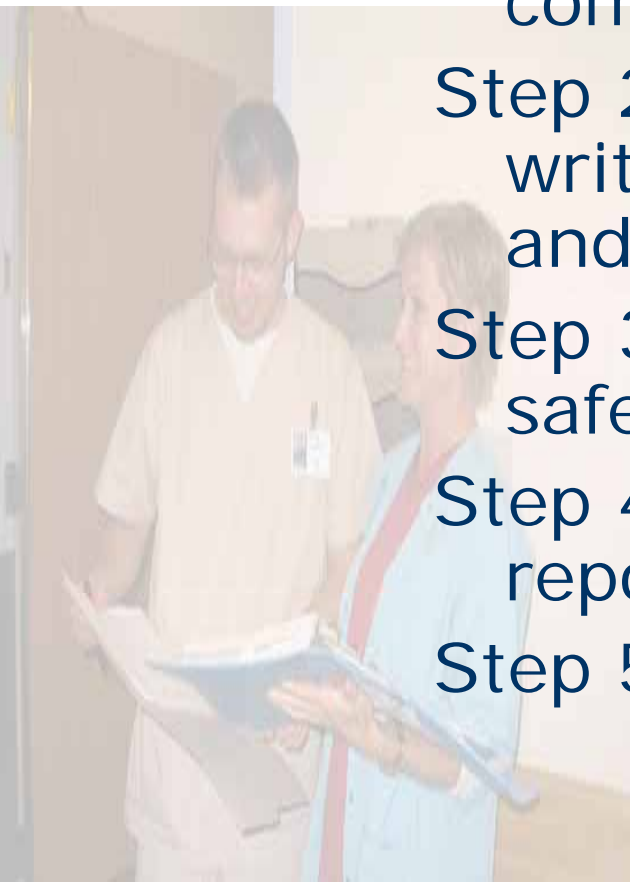
Step 1- Development of unit specific component of TOA standards

Step 2- Development or identification of written tools (both for the staff nurse and the unit leaders/charge nurse)

Step 3- Introduction of bedside patient safety checklist

Step 4- Introduction of face-to-face reporting

Step 5- Evaluation of implementation





Unit-Based Implementation Teams

**Each clinical area engaging in
shift-to-shift report to
identify implementation
team triad**

- Manager
- Educator
- Staff Nurse





Implementation Team Workshops

- Education and information
- Opportunity to learn from each other
- Resource to help meet corporate initiative milestones
- Sessions are cumulative
- Each session addresses one step of implementation
- Work on steps between sessions





Implementation Team Workshops (cont'd)

Staged implementation

- Critical Care
 - ICU, CCU, OR, SDS, L&D
- Remaining in-patient areas divided into group A and group B





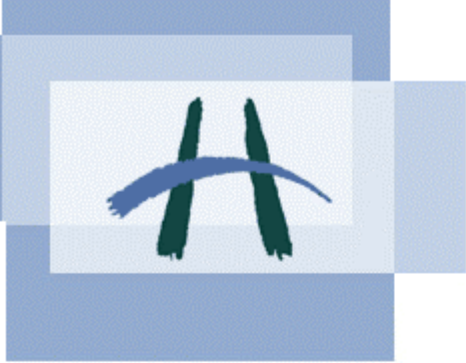
Workshop #1

Standards

Participants:

- Become familiar with the TOA project
- Understand facilitated implementation plan
- Identify communication strategies
- Begin to draft Nursing Standards for Patient Safety During Transfer of Accountability





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(UNIT) Nursing Standards for Patient Safety During Transfer of Accountability

- This information must be communicated when transferring care of the patient
- Each nurse is responsible for documenting that the process of **Transfer of Accountability** and **Patient Safety Checklist** is complete
- Patient's name, age and diagnosis should be stated first

Plan of Care

- | | |
|--|--|
| <ul style="list-style-type: none"> ➤ Code status ➤ Past medical history relevant to current situation ➤ Complications ➤ Patient / Family goals for next 12 hours | <ul style="list-style-type: none"> ➤ Shift orders and future one-time orders ➤ Consults ➤ Infection Control ➤ Medication Administration issues |
|--|--|

Patient Status Review

Vital Signs

Pain

Neurological

Cardiovascular

Respiratory

Gastrointestinal

Genitourinary

Musculoskeletal

Integumentary

Reproductive

Discharge Planning

Family, psycho-social, spiritual, cultural/ linguistic issues

Lab Work & Diagnostic Tests

Intravenous & Invasive Lines/Drains

Bedside Patient Safety Checklist

- | | |
|--|--|
| <ul style="list-style-type: none"> ➤ Armband on patient (or photo) ➤ IV solutions & infusions; matches MAR | <ul style="list-style-type: none"> ➤ Allergies & alerts reviewed ➤ Monitor alarms on ➤ Risk concerns (e.g. restraint use) |
|--|--|



Approval Date: _____

Director: _____

Chief of Nursing Practice: _____

Manager: _____



Workshop #2

Written Tools

Participants:

- Update group re. progress in completing Standards
- Understand purpose of written tools (staff nurse & charge nurse)
- Prepare plan to develop & implement written tools
- Share available written tools
- Begin drafting written tools





Workshop #3

Bedside Checklist

Participants:

- Update group re. progress completing standards and written tools
- Understand purpose & components of bedside patient safety checklist
- Prepare plan to introduce checklist
- Identify method and location for documenting TOA





Workshop #4

Face to Face Report

Participants:

- Update group re. progress introducing checklist
- Understand purpose of face to face reporting
- Prepare plan to introduce/review/revise face to face reporting
- Identify work accomplished to date
- Work on outstanding areas with support of project leads





Workshop #5

Evaluation

Participants:

- Update group re. progress to date
- Prepare plan to conduct evaluation
- Understand expectations for completing implementation





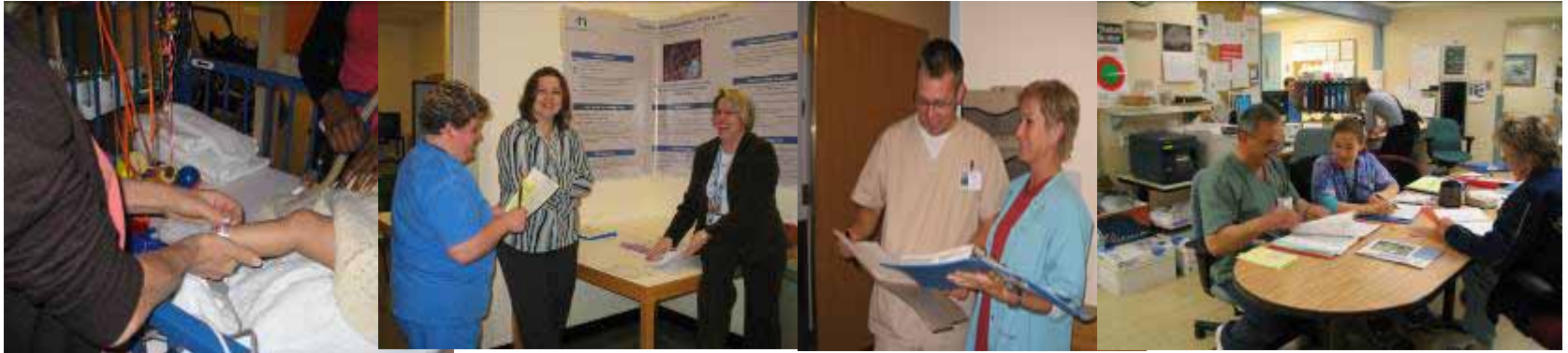
Integration & Sustainability

- Re-convened unit-based teams
 - Completed integration plan
 - Completed sustainability plan
- Quarterly Newsletter
- Policy
- Orientation
- Ongoing observational audits





Challenges & Successes





Observational Audit Results

- A total of 1040 observational audits were submitted
- Audits were completed during the time frame of February 2006 – September 2007





Challenges

- Process change identifies other issues
 - Staff historically late for work
 - Nurse not identified as accountable for patient care (team nursing)
 - Practice issues
- Staff concerns
 - Staying late
 - Breach of patient confidentiality
 - Waking patient to check armband





What do the audits tell us?

- Majority of the time during observational audits TOA occurring as intended
 - 96% face to face
 - 69% using written tool
 - 92% reporting on components
 - 85% documenting TOA appropriately
 - 68% completion of Bedside Patient Safety Checklist





Good News!

95 occurrences or errors were identified during the audits

Occurrence/Error by Type	Number (not all occurrences/errors identified a type)
Armband	22
IV infusion	14
Allergies	7
Monitor alarms	1
Risk issues	9
Other	26 + 16 not identified (42)



Limitations of Audit Data

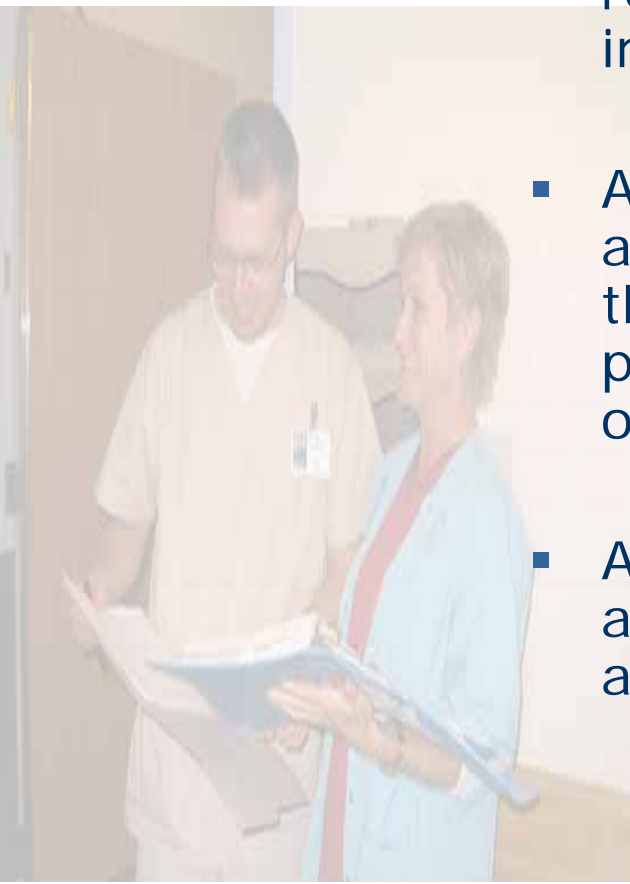
- Audits were conducted at different points in implementation process
- Completion, not quality of TOA is measured by audit
- For some items, there were a significant number of “no response” or “not applicable”





Making a difference

- One pharmacist noted a reduction in IV related medication errors since TOA was implemented.
- A parent described feeling very comforted and pleased to see the nurses completing the bedside patient safety checklist and passing the information directly to the nurse on the next shift.
- A patient also described a feeling of comfort and trust in the staff after having witnessed and participated in TOA.





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