Improving Safe Handoffs & Transitions from the ED to Adult Inpatient: A Response to the AHRQ Hospital Patient Safety Culture Survey

Natalie Talbot  
*Maine Medical Center*

Joanne Chapman  
*Maine Medical Center*

Rhonda DiPhilippo  
*Maine Medical Center*

Gail Savage  
*Maine Medical Center*

Michele Higgins  
*Maine Medical Center*

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Authors
Natalie Talbot, Joanne Chapman, Rhonda DiPhilippo, Gail Savage, Michele Higgins, Nancijean Goudey, Lori Sweatt, Erin Graydon Baker, Joseph East, Stephen Tyzik, Suneela Nayak, Mark Parker, Ruth Hanselman, and Amy Sparks

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Countermeasures

<table>
<thead>
<tr>
<th>Action:</th>
<th>Due Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Map current state (Process)</td>
<td>Nov 15th</td>
<td>Complete</td>
</tr>
<tr>
<td>Map ideal state/Ideal State Revised (Process)</td>
<td>Jan 10th &amp; Jan 31st</td>
<td>Complete</td>
</tr>
<tr>
<td>Create template for safe handoff with relevant content &amp; educate on process and handoff tool</td>
<td>Feb 15th, Mar 3rd</td>
<td>Complete</td>
</tr>
<tr>
<td>Implement 1st test of change: 100% of the time patients admitted from ED to R2 + P3CD will have a verbal handoff utilizing handoff tool</td>
<td>Mar 5th</td>
<td>Complete</td>
</tr>
<tr>
<td>Administer survey to R2, P3CD, and ED staff assessing perceptions of handoff process</td>
<td>May 5th</td>
<td>Complete</td>
</tr>
<tr>
<td>Spread to other units: Educate staff nurses</td>
<td>July-Oct</td>
<td>In Progress</td>
</tr>
</tbody>
</table>

Outcomes

1. NEW “Pull” Process

2. Balancing Measure:
   - ED transport
   - Pilot started

3. Outcomes*
   - We noted at least a 5% improvement in the handoffs questions from the baseline on all units. 103 total responses.

Lessons Learned & Next Steps

1. Improving handoffs is culture change, which takes time. Providing time for consensus building. Setting guiding principle for the team was essential.
2. Sustainability: Next steps have included expanding to all patients admitted from ED to any inpatient unit. Expanding the same verbal handoff process to PACU admissions.
3. Next steps also include optimizing handoff tools in the electronic health record.
4. Working with others in our health system allows for sharing of ideas and tools. The tool used originated from one of the other hospitals, then edited.

Plan/Impact Statement:

**Background:** Handoffs and Transitions was the lowest scoring domain in the 2016-17 AHRQ Hospital Survey on Patient Safety Culture falling below the national average (48%) at our health system, in all 8 of our hospitals. As a result, each hospital implemented an initiative to improve Handoffs. There are 4 questions included in the Handoffs and Transitions Domain of the survey. The question ‘Things fall between the cracks when transferring patients between units’ was the lowest scoring at Maine Medical Center (MMC), a 637-bed, academic, Magnet hospital. In September 2017, The Joint Commission issued a Sentinel Event Alert indicating handoffs should include at minimum a structured approach with a verbal handoff, providing further support to the area of focus.

**Problem statement:** Upon further analysis, it was identified that there was no standard process for verbal handoff of patient care information when transferring patients between ED and inpatient units at MMC.

**Aim and Goals:**

1. **Outcome:** We aim to improve the Handoffs and Transitions Domain and the question: ‘Things fall between the cracks when transferring patients between units’ of the AHRQ Patient Safety Culture Survey by 5% from the 2017 baseline by December 2018 in ED, R2 and P3CD.

2. **Process:** Establish a process for incorporating a verbal handoff 100% of the time for all patients who are admitted from the ED to R2 + P3CD using an evidence based mnemonic tool to structure the content by March 5th, 2018.

**Current State:**

We noted several steps in the process to be out of scope. The blue star highlights the steps in the current state that we could improve, including implementing the standard verbal handoff process. As a result, a Balancing Measure for this project included monitoring ED to floor times for patient flow.

Root Cause Analysis:

**Communication:**

1. There is a standard process to notify the ED of an admission.
2. There is a verbal communication standard to notify the floor of an admission.
3. There is a verbal communication standard to notify the ED of an admission.
4. There is a verbal communication standard to notify the floor of an admission.
5. There is a verbal communication standard to notify the ED of an admission.

**One Call Central (OCC):**

1. OCC requires the process to be verbal.
2. OCC requires the process to be verbal.
3. OCC requires the process to be verbal.
4. OCC requires the process to be verbal.
5. OCC requires the process to be verbal.

**People:**

1. Patients provided for involved patient care professionals.
2. Nurse, nurse assistants, provided verbal patient care professional.
3. Nurse, nurse assistants, provided verbal patient care professional.
4. Nurse, nurse assistants, provided verbal patient care professional.
5. Nurse, nurse assistants, provided verbal patient care professional.

**Lessons Learned & Next Steps**

- **1. Improving handoffs is culture change, which takes time. Providing time for consensus building. Setting guiding principle for the team was essential.**
- **2. Sustainability:** Next steps have included expanding to all patients admitted from ED to any inpatient unit. Expanding the same verbal handoff process to PACU admissions.
- **3. Next steps also include optimizing handoff tools in the electronic health record.**
- **4. Working with others in our health system allows for sharing of ideas and tools. The tool used originated from one of the other hospitals, then edited.**

**Improving Safe Handoffs & Transitions ED Adult Inpatient: A Response to the AHRQ Hospital Patient Safety Culture Survey**

**Date:** September 2018

**Executive Sponsor:** Marjorie Wiggins, CNO & Omar Hasan, VP, Quality and Safety Facilitator & Project Lead: Natalie Talbot, MSN, RN

**Team Members:** Joanne Chapman, MSN, RN, Rhonda DiPhilippo, MSN, RN, Gail Savage, RN, Amanda Bennett, RN, Heidi Bowen, RN, Nancieeans Goudey, RN, Melissa Fairfield, RN, Lori Sweatt, RN, Sara Moon, RN, Sarah Sturges-Perry, RN, Tracie Lowe, RN, Jennifer Plocharczyk, RN, Michele Higgins, RN, Angela Smith, RN, Brandi Lovering, RN, Erin Graydon Baker, Director Safety and Risk, Joe East, Manager, Tele-tracking, Stephen Tyzik, Suneela Nayak, Ruth Hanselma, Amy Sparks