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

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

Date: September 2018

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## Problem/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.

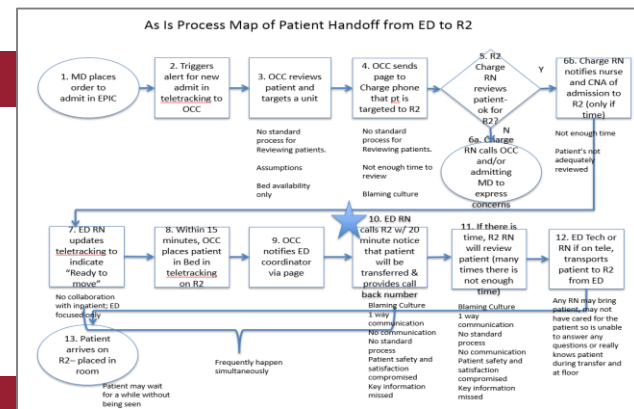
**Problem statement:** Upon further analysis, it was identified that there was no standard process for verbal handoff of patient care information when transferring patients between ED and inpatient units at MMC.

## Aim and Goals:

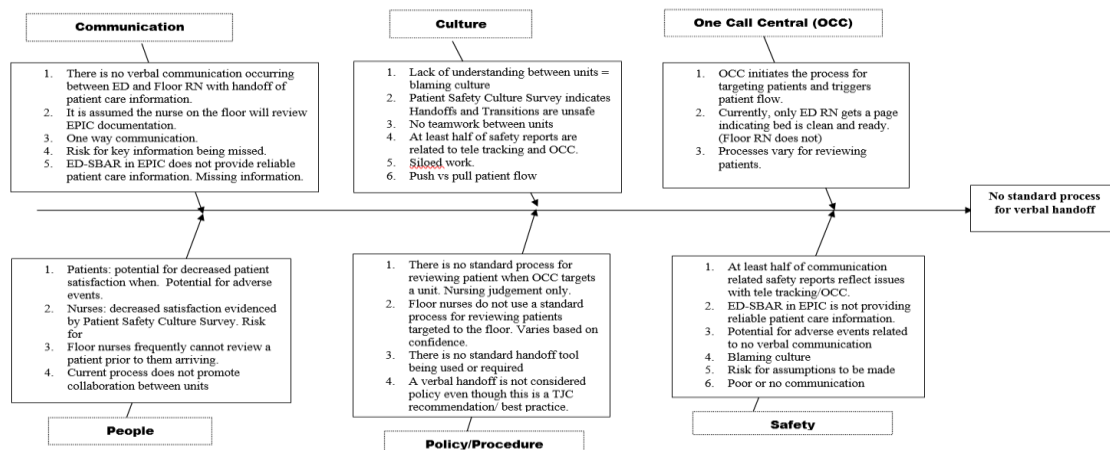
- Outcome:** We aim to improve the Handoffs and Transitions Domain and the question: ‘Things fall between the cracks when transferring patients between units’ of the AHRQ Patient Safety Culture Survey by 5% from the 2017 baseline by December 2018 in ED, R2 and P3CD.
- Process:** Establish a process for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



## Countermeasures

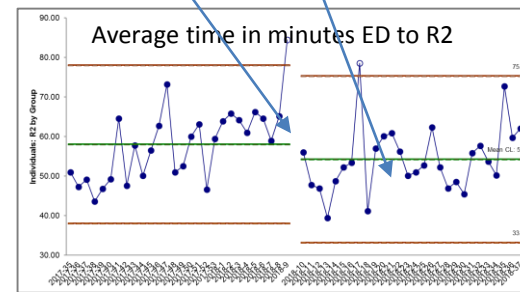
Action:	Due Date	Status
Map current state (Process)	Nov 15 <sup>th</sup>	Complete
Map ideal state/Ideal State Revised (Process)	Jan 10 <sup>th</sup> & Jan 31 <sup>st</sup>	Complete
Create template for safe handoff with relevant content & educate on process and handoff tool	Feb 15 <sup>th</sup> - Mar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

## Outcomes

1. **NEW “Pull” Process** →

2. **Balancing Measure:**

Verbal Handoff Started  
ED transport Pilot started

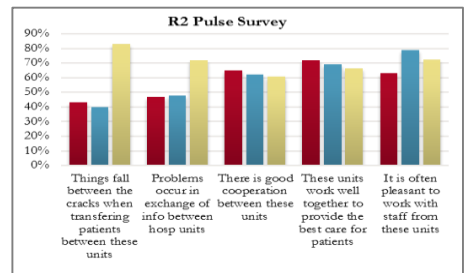
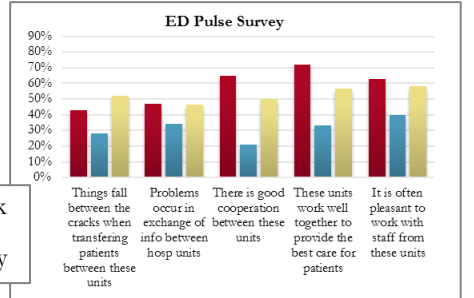
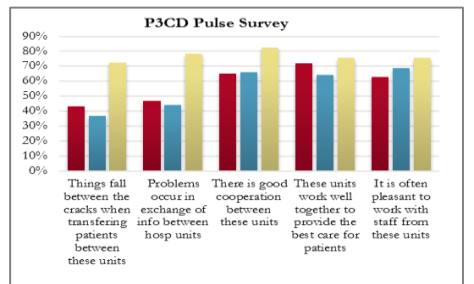


3. **Outcomes\* →**  
We noted at least a 5% improvement in the handoffs questions from the baseline on all units. 103 total responses.

Red= AHRQ Benchmark  
Blue= 2017 Baseline  
Gold= 2018 Pulse Survey

## Lessons Learned & Next Steps

- Improving handoffs is **culture change**, which takes time. Providing time for consensus building. Setting guiding principle for the team was essential.
- 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.
- Next steps also include optimizing handoff tools in the electronic health record.
- 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.



\*Questions were adapted from AHRQ survey to assess the new process

Plan

Do

Study

Act