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The Handoff Culture: Can we change how an ICU to floor transfer works?

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The Handoff Culture: Can we change how an ICU to floor transfer works?

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ABSTRACT

Handoffs between providers have increased following the implementation of the 2011 Accreditation Council for Graduate Medical Education (ACGME) work hour restrictions. Properly structured and timed handoffs are essential to patient safety.[1] Despite this, studies have shown that errors in code status, medication allergies, and important updates to the problem list are common, all of which can lead to adverse outcomes to patients.[2]

At Thomas Jefferson University Hospital (TJUH) the 2016 Safety Culture Survey revealed that across all specialties, 37% of residents felt that things "fall through the cracks" when transferring patients from one unit to another.

Our interdepartmental Housestaff Quality and Safety Leadership Council (HQSLC) sought to evaluate and modify the TJUH ICU to floor handoff process. Through engaging our diverse membership, we realized that the ICU to floor handoff process at TJUH lacks standardization. The following areas demonstrated a high degree of variation, and were seen as targets for improvement:

- **Timing of handoff**: Some departments give the handoff at the time of transfer order, and others at bed assignment.
- **Incorporation of best practices**: Both verbal and written handoffs should be performed with time for follow up questions by the receiving team
- **Closed loop communication**: Both sending and receiving teams should clearly communicate the plan of care, and the receiving team should clearly indicate when they have taken over primary responsibility.

OBJECTIVES

We aimed to improve the handoff process such that:

1. A closed loop process will be implemented such that both sending and receiving teams share a mental model for handoff readiness
2. Resident comfort with handoffs will improve as measured by the Hospital Survey on Patient Safety Culture

INTERVENTION

We engaged HQSLC members, the patient flow management center, and MICU nursing and physician leadership, identifying two SMART Aims:

1. 100% of patients leaving the ICU will have a bedside team evaluation prior to transfer
2. 75% of <u>receiving teams</u> will attest that verbal and written handoff has occurred prior to patient transfer to the floor

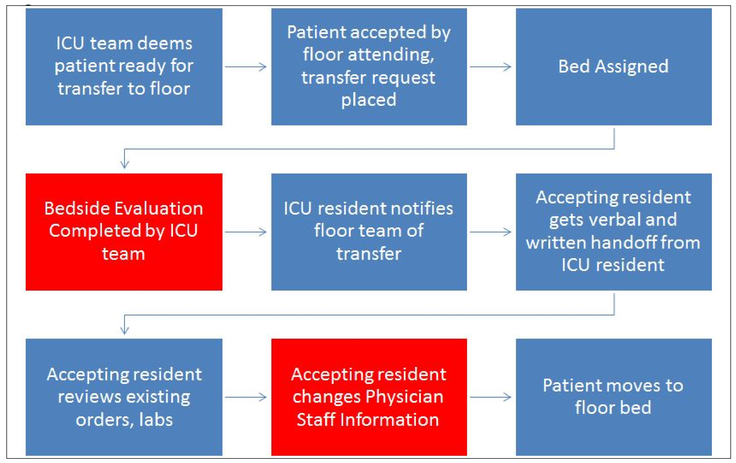

Figure 1: Proposed change to process map of current ICU to floor transfer process, red highlighting proposed changes

RESULTS

Only 13.6% of patients transferred out of the ICU had a bedside evaluation documented prior to transfer. Debriefing with MICU residents revealed -

- Too much time required to complete the bedside evaluation, detracted from ability to care for other critically ill patients or be present on rounds
- Many transfers occurred overnight when resident was less familiar with patient's plan of care, and staffing rations are reduced

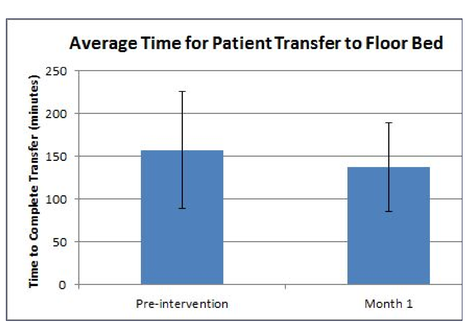

Figure 2 (left): Time from assignment of floor bed to transfer of patient out of the ICU was not significantly increased by our interventions, though there was only modest compliance with the proposed process.

RESULTS

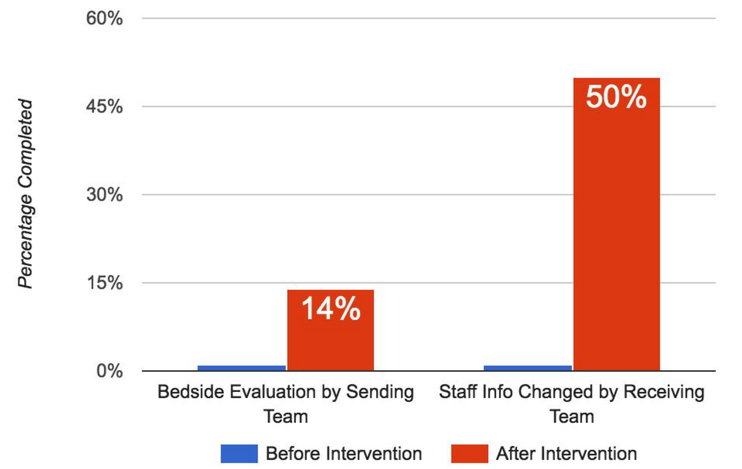

Figure 3: Comparison of completion of bedside evaluation prior to transfer from the ICU team to the floor team and staff information being changed by receiving team prior to our intervention and after, showing increases in both but a larger increase in staff information being changed.

DISCUSSION/REFLECTION

Based on our pilot we conclude the following:

1. Modest rates of compliance with changing staff info by accepting teams suggests culture is changeable
2. Low rates of compliance with documentation of bedside evaluation may be related time concerns in already busy environment.
3. Early wins with EPIC: receiving team responsible for order reconciliation at transfer, implementation of a transfer SmartPhrase to document bedside evaluation

We did not reach our goals on this pilot, likely because of:

1. Poor timing of intervention – coincided with major institutional change to new EMR
2. Need for unified leadership support for improvement driven from the top down

Future goals include:

1. Aim to standardize process across our different ICUs. Given handoffs happen between departments, TJUH should strive for a unified reliable process. Leadership support will be essential.

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2. Aylward, M. J., Rogers, T., & Duane, P. G. (2011). Inaccuracy in patient handoffs: discrepancies between resident-generated reports and the medical record. Minnesota medicine, 94(12), 38-41.