GREATER NEW YORK HEALTH CARE FACILITIES ASSOCIATION

We will begin shortly!

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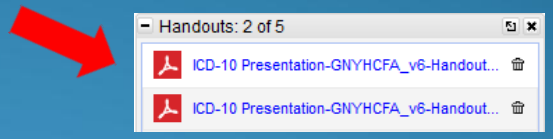

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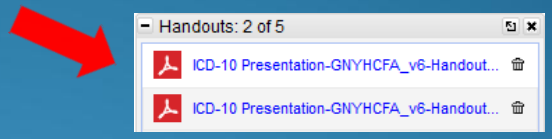
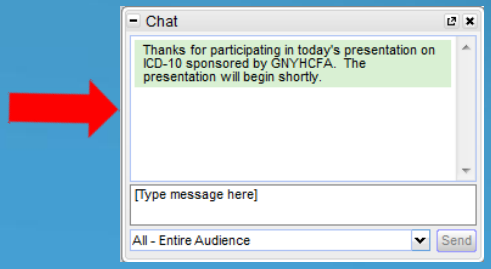


- Today's session is being recorded for replay
- Attendees will be in "Listen only" mode
- Use Chat box on right to submit questions
- Q&A at the end of today's presentation



GREATER NEW YORK HEALTH CARE FACILITIES ASSOCIATION

Sponsor

Greater New York Health Care Facilities Association

Mary Gracey-White, RN, Regulatory Compliance Coordinator

Presenter

Edward Leigh, MA, Founder and Director of The Center for Healthcare Communication

Avoid Devastating Handoff Errors: How to Make Transitions of Care Efficient and Safe

Presented by:

Edward Leigh, MA

1-800-677-3256

www.CommunicatingWithPatients.com

CMS Regulations: Communication

- F572 A Facility must have an effective communication system across all shifts for communicating necessary care and information between staff, practitioners and residents/resident representatives information.
- All staff must have knowledge and skill sets to effectively communicate with residents
- F941 Phase 3 Effective 11/28/19- A Facility must include effective communication as a Mandatory Inservice for direct care staff.

Mom saw her primary care physician, who diagnosed her with atrial fibrillation and a possible Deep Vein Thrombosis (DVT). The office called a local Emergency Dept (ED) and mentioned the two issues; they called an ambulance and mentioned that Mom would be there soon. I also called / faxed the ED to mention the two issues. I arrived at the ED as Mom was being discharged. The ED nurse said the doctor did not believe Mom had atrial fibrillation. I asked about the possible DVT – they said this was the first time they heard about this issue.

Communication Breakdown	**Solution**

Program Objectives

- Practice methods of preparing for the handoff.
- Demonstrate effective strategies to handoff resident information.
- Apply methods of handling situations where the handoff cannot be accepted (more info needed).

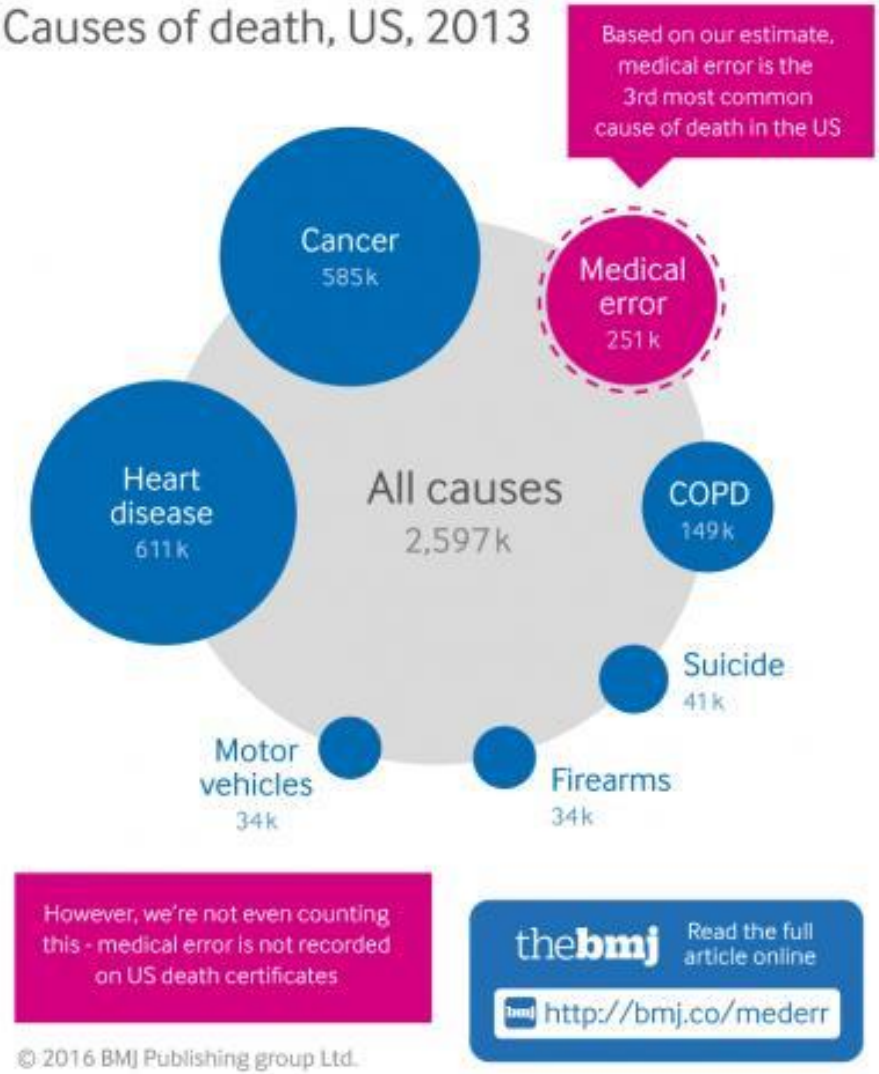
Definition of Handoff

According to the Merriam-Webster Online Dictionary, "Handoff" is described as, "To hand (a football) to a nearby teammate on a play."

Every single conversation about a resident is a handoff!

We have protocols for medical procedures.

We need protocols for how we communicate with each other regarding residents.


Causes of death, US, 2013
Based on our estimate, medical error is the 3rd most common cause of death in the US
Cancer
585k
Medical error
251k
Heart disease
611k
All causes
2,597k
COPD
149k
Suicide
41k
Motor vehicles
34k
Firearms
34k
However, we're not even counting this - medical error is not recorded on US death certificates
thebmj
Read the full article online
http://bmj.co/mederr
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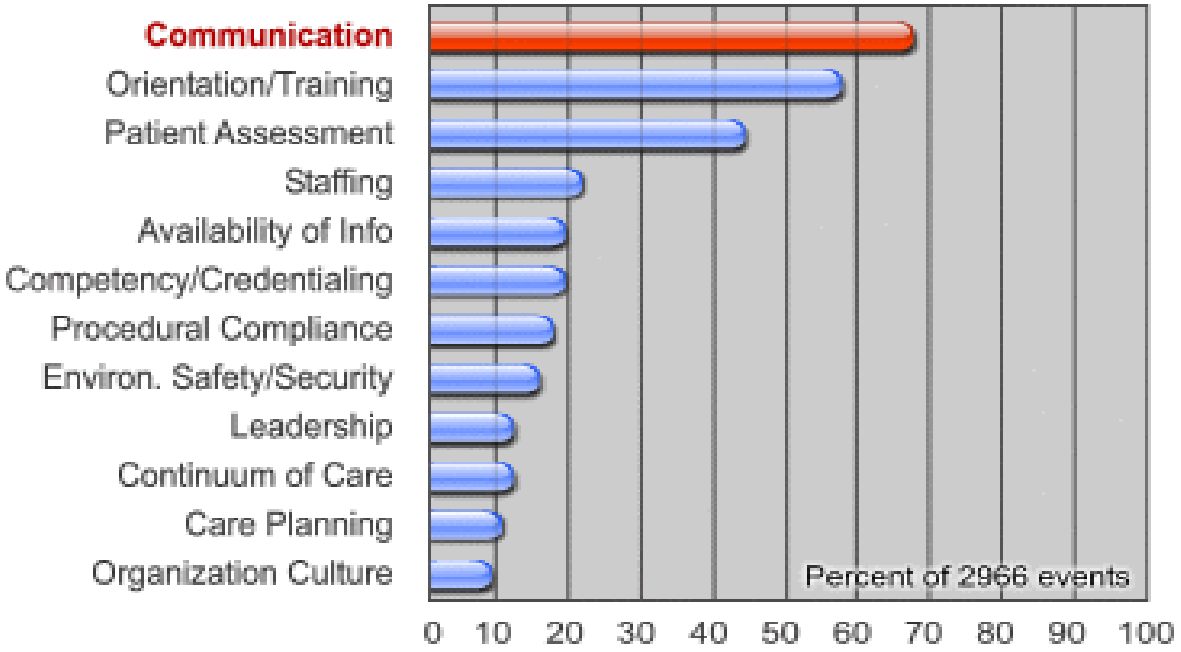
Data source: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

According to the Joint Commission, “An estimated 70-80 percent of serious medical errors involve miscommunication between caregivers when responsibility for patients is transferred or handed-off.”

In addition to patient harm, defective hand-offs can lead to delays in treatment, inappropriate treatment, and increased length of stay in the hospital.

Root Cause of Sentinel Events (All Categories; 1995-2004)

(According to the Joint Commission)



A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury.

Preparing for Handoffs

Utilize a quiet space or room, if possible. This area / room should include computers so professionals can access resident / patient data and other important information.

Avoid interruptions (as much as possible). It is important to limit distractions caused by pagers, phone calls, etc., except in cases of emergencies. If an interruption occurs, the professional should begin the patient discussion form the start and not try to find where they left off.

Allocation of sufficient time. Everyone is very busy, however an appropriate amount of time must be allocated to insure for communicating critical information and for staff to ask and answer questions (using the check-back method – discussed later).

The Telephone Game

The Telephone Game. Children sit or stand in a circle and whisper a message into the ear of the person next to them. By the time the original message gets to the last child -- the message is usually quite different than the original message. Kids usually laugh during this process.

Poorly done handoffs can lead to "Telephone Game" results – botched information, which is no laughing matter.

Techniques for Clear Communication

Be precise. Avoid expressions like, “Resident seemed a little confused.” What does, “a little,” mean? Words like, “kinda,” and “sorta” are also ambiguous.

Caution with abbreviations. HL may mean Hyperlipidemia to you and Hodgkin's Lymphoma to another professional.

Avoid interrupting. Let the “sender” complete their report of information before asking questions.

Brevity. Think about what are the most important pieces of information. Rather than put everything out there initially, think about what is most vital and mention that information first. If you had to pick the 2-3 most important items about the resident – what would you say?

Problem with using Abbreviations

CD could mean

curative dose

compact disk

caesarean delivery

cardiovascular disease

Celiac disease

chemical dependency

chronic dizziness

contagious disease

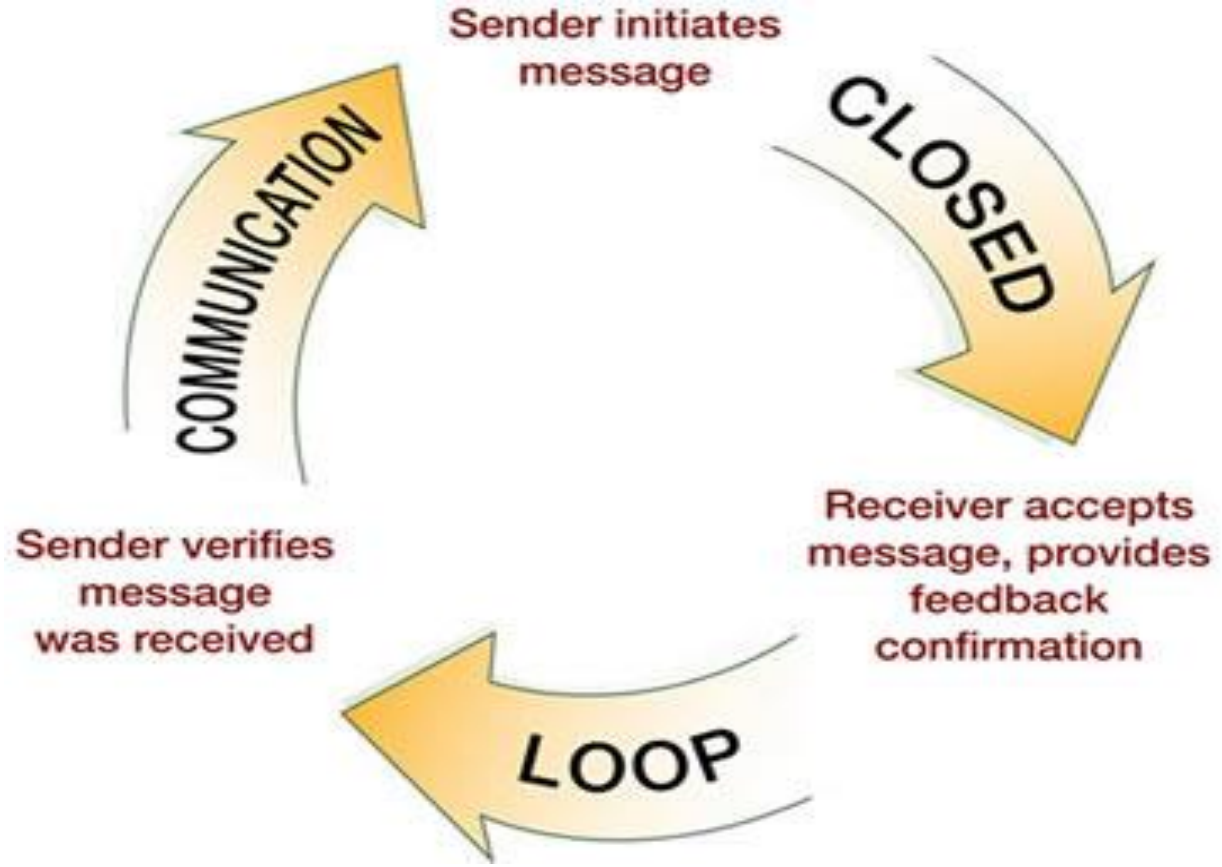
coronary disease

Crohn's disease

cumulative dose

Cushing disease

Check Back Method



Slide courtesy of the Agency for Healthcare Research and Quality

Check Back Method Example

Nurse:	Hello. This is Sandy Stevens, RN
Lab Tech:	Hello. This is Bob King. I am calling with the lab results for Mr. John Smith, ID #12345678. Mr. Smith's potassium level is 5.1, which was drawn at 0700 today.
Nurse:	(writing the info). I understand John Smith's potassium is 5.1.
Lab Tech:	Yes, that is correct. John Smith's potassium level is 5.1. Thank you.

Standardizing Handoffs – SBAR

Situation

What is going on with the resident / patient? (Complaint, diagnosis, treatment plan and patient's wants and needs) 1-2 sentences.

Background

What is the clinical background or context? (Vital signs, mental and code status, list of medications and lab results)

Assessment

What do I think the problem is? (Current provider's assessment of the situation). Summarize your observations.

Recommendation

What would I recommend? (Identify pending lab results and what needs to be done over the next few hours and other recommendations for care)

Allow for Questions & Answers

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SBAR Case Study (LTC example)

This is an example of an aide speaking with a nurse about a resident.

Situation: “Mrs. Smith fell asleep in her clothes this evening and cursed at me.”

Background: “She is 85 years old and in room 123; she is usually pretty friendly.”

Assessment: “She seems OK physically, but I’m worried.”

Recommendation: “I’d feel better if you would take a look at her and make an assessment.”

SBAR Article – focused on LTC setting

“The majority (87.5%) of nurse respondents found the tool (SBAR) useful to organize information and provide cues on what to communicate.”

Source: Renz SM , Boltz MP , Wagner LM , et al . Examining the feasibility and utility of an SBAR protocol in long-term care. Geriatr Nurs 2013;34:295–301.

SBAR Benefits

- Creates a standard tool of communication (everyone on the "same page")
- Removes issues of hierarchy (i.e., levels the playing field).
- Saves time by removing extraneous details. (A SBAR briefing can be done in as little as 60 seconds.)
- Reduces deaths, injuries and malpractice claims.

Success Story:

"The introduction of SBAR made shift reports more focused, with more time spent discussing the patient and less on transcribing information. The SBAR protocol provides a concise and prioritized structure that enables consistent, comprehensive, and patient-centric reports."

Cornell P1, Gervis MT, Yates L, Vardaman JM. Improving shift report focus and consistency with the situation, background, assessment, recommendation protocol. J Nurs Adm. 2013 Jul-Aug;43(7-8):422-8

I-PASS

BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

I PASS Success Story

A three-year, multicenter study using IPASS on more than 11,000 patients published in the New England Journal of Medicine found:

Overall rate of medical errors	23% reduction
Preventable adverse events	30% reduction
Duration of handoff	No change

Reference: Starmer AJ, Spector ND, Srivastava R, et al, for the I-PASS Study Group. Changes in medical errors after implementing of a handoff program. N Engl J Med. 2014;371:1803-1812.

For more information about the I-PASS Handoff Strategy, please visit this website:

http://www.ipasshandoffstudy.com

Discharge to Home

Handing Off Residents to Family Members

Beth is taking her mother, Margaret, a long-term care resident who is wheelchair dependent, out for the afternoon to attend a family gathering. As the nurse is signing out Margaret for the leave of absence, she tells Beth, "Your mother is at risk for pressure ulcers now that she uses the wheelchair. Her skin is intact and she will be fine as long as you reposition her at least every 2 hours." Later that evening, during evening care, the nursing assistant reports that Margaret has an open area on her coccyx. The nurse calls Beth. Beth, sounding confused, says, "How could this have happened? I did just as you said, I turned her chair every 2 hours!"

Source: Agency for Healthcare Research and Quality

Discharge to Home

Handing Off Residents to Family Members

- Use the “Check Back” method to verify the information was communicated correctly.

- Consistent messages among professionals. Be sure all professionals provide the same type of instructions to avoid confusion on the part of the family member..

- Clear jargon-free discharge instructions written at a sixth-grade level. Include visuals. Highlight key areas with a highlighter or pen

- Helpful resource on effective discharge planning:

http://www.endonurse.com/articles/2015/05/effective-patient-discharge-communication-in-the.aspx

Conflicts During Handoffs

One Team. Everyone in the LTC is ultimately on the same team. Each department / professional is not an opposing team.

Empathize. Think about the responsibilities of other professionals you work with to help you understand their experiences.

Conflict is a natural process, but needs to be handled tactfully. For example, if you disagree with colleague, do not state, “You are absolutely wrong!” A better statement is, "I respectfully disagree ..." Focus on “I” statements, not “you” statements. People make the mistake of always trying to avoid conflict, however conflict can be an excellent learning experience if handled appropriately.

Conflicts During Handoffs

Most problems with catheter use stem from poor physician-nurse communication, according to this study. All respondents said poor communication delayed removal of unnecessary catheters. Communication broke down for various reasons and on many levels, including:

-- poor relationships between doctors and nurses

-- hierarchical differences

Study Source:

Milisa Manojlovich, Jessica M. Ameling, Jane Forman, Samantha Judkins, Martha Quinn, Jennifer Meddings. Contextual Barriers to Communication Between Physicians and Nurses About Appropriate Catheter Use. American Journal of Critical Care, 2019; 28 (4): 290

Implementing Handoff Strategies

Select Tool. After reviewing the resources, select the tool that bets meets your needs. For some organizations it could be SBAR, while others may prefer IPASS.

Assessment. Survey staff members to determine their needs. What do they struggle with in regards to transitions of care? Ask about tools they are currently using to create successful transitions of care

Develop Training. After your selection of the right tools and assessment process, develop a training and be sure all staff are properly trained.

Reinforcement. Use it or lose it! Continually remind staff about the handoff tools. Ask for examples as to how they are being implemented.

Resources

I-PASS Handoff Strategy

Outstanding worksheets and toolkits on implementing I-PASS in healthcare organizations.

http://www.ipasshandoffstudy.com

National Transitions of Care Coalition

Excellent tools and resources to improve handoffs.

http://www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx

SBAR Toolkit

The Institute for Healthcare Improvement has an excellent toolkit to help implement SBAR in healthcare organizations.

http://www.ihi.org/resources/ Pages/Tools/sbartoolkit.aspx

TeamSTEPPS

The Agency for Healthcare Research and Quality has excellent LTC-specific materials.

http://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/module6/igltccommunication.html#sbarsl9

Program Objectives

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Questions

Handoffs
are all about Teamwork

Hi!
I’m Monty!
I hope you learned a lot at this GNYHCFA Webinar!

For more Information

Edward Leigh, MA

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