



A Culture of Patient Safety: Crucial Communication

By Gayle Thompson Smillie, CRA, RT

In 2006, The Joint Commission identified handoff communication as essential to keeping patients safe within the hospital environment.¹ Yet ineffective communication is the most frequently cited category of root causes of sentinel events. National Patient Safety Goal (NPSG) 2E requires that a standardized approach to handoff communication be implemented, the goal being to increase effectiveness, reduce error, and improve patient safety. Washington Hospital Center (WHC) in Washington, DC has focused a lot of effort on improving handoff communication. Other industries (eg, NASA, the nuclear power industry, and transportation dispatch centers) have developed a strategic framework for handoffs:

- Standardized face-to-face verbal communication with opportunity for questions is supported by evidence and expert opinion to be best practice.
- A one-size-fits-all approach will not work. The handoff should be tailored to the users, the environment (ED, ICU, radiology, etc), and the type of patient.
- Reduce variation.
- Highlight that the handoff is the transfer of professional responsibility.

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America Medical Systems, Inc. Putting Patients First grant, the subsequent funding was used to host a conference in November 2009 titled, “A Culture of Patient Safety: Crucial Communication.”

The conference presented three lectures discussing safety related topics:

- “Culture Eats Strategy for Lunch: Uncovering What We Mean By a Culture of Safety”
- “Patient Handoffs: Critical to Safety and Learning”
- “The Washington Hospital Center Experience: It’s All About Keeping the Patient Safe”

The objectives of the conference were to:

- Illustrate basic and subtle meanings of a culture of safety
- Evaluate interactions within institutions that create challenges to sustaining a culture of safety
- Describe a model for developing communication protocols and evaluation methods
- Share real world experiences related to handoff communications within the hospital setting

The Meaning of a Culture of Safety

The first speaker was Stephen Schenkel, MD, chief of emergency medicine at Mercy Medical Center in Baltimore, MD and assistant professor of emergency medicine at the University of Maryland School of Medicine. Dr. Schenkel spoke about the definition of culture, which is based on actions, attitudes, beliefs, and traditions. Culture forms the foundation of any patient safety structure. Different strategies, projects, and objectives can affect institutional culture in ways that may advance or challenge patient safety.

Dr. Schenkel presented several case studies and evaluated how various interventions interact with an institution’s culture and address the challenges to sustaining a culture of safety. One example highlighted the way in which miscommunication can have adverse affects on patients. An ED patient who had an abdominal CT began complaining of a headache. The ED physician ordered a head CT. Later, when the physician returned to see the patient, he called CT for the results. He asked, “How did the CT look?” and CT answered that it was negative. CT was relaying the results of the abdominal CT, but the physician was referring to the

head CT. Within the hospital, we all live in relative worlds, where even language is different. The word “stable” means very different things to radiology versus the ED versus an ICU. Dr. Schenkel also presented recent patient safety literature as it relates to a culture of safety. He stated the importance of measuring a culture of safety and recommended a blameless reporting system for incident or occurrence reports. Encourage people to report in what must be a non punitive system.

Sustaining Standard Handoff Models

The second lecture was presented by Vineet Arora, MD, assistant professor of medicine, internal medicine residency at the University of Chicago, and assistant dean at the Pritzker School of Medicine. Dr. Arora’s lecture was titled, “Patient Handoffs: Critical to Safety and Learning.” She observed that, for most industries that operate 24/7, the exchange of information that occurs during shift change is critical for maintaining continuity and safety in the workplace. The complexity of the handoff process presents a “vulnerable gap” in patient care that can result in errors, near misses, and adverse patient events. Consequently, handoffs have become a focus of worldwide patient safety improvement efforts. The World Health Organization (WHO) listed “communication during patient care handovers” as one of its High 5 Patient Safety Initiatives.² What started in 2006 as The Joint Commission’s NPSG 2E to develop a standardized approach to handoff communications has now become part of the Provision of Care Standard.

The goal is particularly challenging for academic teaching hospitals that train residents in maintaining the enthusiasm of the initial effort. The handoff process is highly variable and discipline specific. Medical trainees receive little or no formal training or education about communication during handoffs. Also, as academic teaching hospitals continue to adopt systems to ensure resident duty-hour restrictions are met, an increased focus on the integrity of the handoff is crucial to patient safety. Residents (especially interns who do the bulk of

handoffs) function as a transient workforce. The turnover every year makes system improvements difficult to sustain.

In 2005, the University of Chicago developed a model for dissemination and training for effective handoff communication. The model uses 2 principles:

- Principle 1: Handoffs are discipline specific and organization specific.
- Principle 2: Standardization is the core goal for both handoff process and content.

Situation, Background, Assessment, and Recommendation (SBAR) is a nationally recognized model for standardizing handoff communication, originating in the United States Navy, and used by Kaiser Permanente to improve nurse to physician communication. In order to evaluate the handoff communication process, Dr. Arora recommends process mapping to identify every step and opportunity for improvement.³ Information technology (IT) alone can help handoffs, but cannot substitute for a successful act of communication. Structural templates and checklists also help, but are not the total answer. In her endeavors at the University of Chicago, Dr. Arora lists the following lessons learned:

1. Institutional endorsement by leaders is necessary to make the change part of the culture.
2. Although compliance is a strong lever, it can also undermine participants’ recognition that the improvement is important.
3. A one size fits all approach will not work; to achieve sustained change, one needs to tailor the intervention to the local environment.
4. Determine appropriate measurement to be used in the monitoring effort and plan for the resources necessary for monitoring.

The WHC Experience

The third presentation was an interdisciplinary panel discussion of real world experiences at WHC. The panel had

representatives from physicians, nursing, radiology, respiratory medicine, CT, patient transport, and telemetry. A brief history of efforts to sustain a culture of patient safety was discussed, which included the development of a handoff checklist form. Handoffs occur between physicians, nurses to physicians, residents to residents, shifts to shifts, and nursing to ancillary departments.

In January 2007, WHC’s interdisciplinary handoff communications committee was formed and charged with developing a standardized handoff protocol and to create a form to facilitate the process. A literature search assisted the group to identify best practices, in which two articles excelled in fostering the creation of the form.^{4,5}

In 2006, the hospital implemented SBAR as the handoff model for use by nurses and physicians. The handoff checklist form (Figure 1) was then developed using the SBAR format, and assigned a travel status to the patient as green, yellow, or red. Green means the patient is safe to travel, yellow signals the department to expedite the patient, and red means that a nurse must accompany the patient. Education and re-education is ongoing. It is important for staff to understand that it’s not about filling out the form, it’s about keeping the patient safe. One ICU attending physician calls it “cocooning” the patient. However, the form is useful only if it aids critical thinking skills and begs the question, “Is my patient safe to travel?”

Additionally, a variety of initiatives have resulted from handoff improvement efforts, including installation of direct phone lines from ancillary areas to telemetry, education regarding the speed at which e-tanks of O₂ empty, and patient transporters’ refusal to transport without the handoff form. The handoff form identifies patient vulnerabilities for the receiving caregiver. This essential information is helping us sustain a culture of patient safety.

Conclusion

The conference was attended by a cross-section of disciplines, including nursing, residents, fellows, radiology techs, radiology students, transporters, respiratory therapy,



PATIENT SAFETY HANDOFF TRAVEL FORM

To be Completed by Receiving Departments		
To be completed by 1st Receiving Department. Dept.:	<p>If patient on telemetry:</p> <input type="checkbox"/> Upon arrival , Telemetry called, given department call back number, and verified that signal is visualized: Time: _____ Initials: _____	<input type="checkbox"/> Exam/procedure/treatment is complete & no change in patient condition unless noted below: _____ _____ _____ Printed Name: _____ Extension: _____ Signature: _____ Date/Time: _____
To be completed by 2nd Receiving Department. Dept.:	<p>If patient on telemetry:</p> <input type="checkbox"/> Upon arrival , Telemetry called, given department call back number, and verified that signal is visualized: Time: _____ Initials: _____	<input type="checkbox"/> Exam/procedure/treatment is complete & no change in patient condition unless noted below: _____ _____ _____ Printed Name: _____ Extension: _____ Signature: _____ Date/Time: _____
To be completed by 3rd Receiving Department. Dept.:	<p>If patient on telemetry:</p> <input type="checkbox"/> Upon arrival , Telemetry called, given department call back number, and verified that signal is visualized: Time: _____ Initials: _____	<input type="checkbox"/> Exam/procedure/treatment is complete & no change in patient condition unless noted below: _____ _____ _____ Printed Name: _____ Extension: _____ Signature: _____ Date/Time: _____
Patient Travel Categories		
RED:	<ul style="list-style-type: none"> Requires an RN or LIP to accompany patient, request to have portable test if feasible on unit, or reassess need for test/ procedure in consultation with physician Initiate request for physician order to transport if necessary A Red travel category requires a telephone call from the home unit to the receiving department prior to the patient leaving the home unit Patient can be off unit for short periods of time only Test/service will be performed immediately Patient will depart testing area immediately after test is completed 	GREEN:
YELLOW:	<ul style="list-style-type: none"> Patient requires closer supervision If a patient has multiple "Yellow" boxes checked, sending unit reassesses to determine safety to transport/consult with physician as necessary Transporter tells department about patient's travel category Test/ service must be performed as soon as possible Patient departure from test/ service area will be expedited 	GREEN:
GREEN:	<ul style="list-style-type: none"> Patient travels by routine transport and wait time procedures Transporter tells department about patient's category 	GREEN:
Initials	Signature	Print Name

PATIENT LABEL

**PATIENT SAFETY
HANDOFF
TRAVEL FORM**

FORM 2282 rev09/15/08 96479 (Front) pg 2 of 2

Figure 1 • Handoff checklist form (continued).

and physicians. The attendees appreciated the interactive structure the speakers utilized. There was a lively question and answer period for the WHC interdisciplinary panel. In WHC's experience, while this handoff model is generalized, frontline buy-in is very important. Engaging people during process improvement initiatives and the ongoing monitoring process will have more positive results. The bottom line: it's all about keeping the patient safe. We would like to acknowledge and thank AHRA and Toshiba Medical Systems for the funding to support this program. The grant enabled us to offer a forum to share best practices within WHC and with our area colleagues. We also thank Dr. Arora and Dr. Schenkel for their input, recommendations, and expertise. ☸

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Gayle Thompson Smillie, CRA, RT is director of radiology at Washington Hospital Center in Washington, DC. She can be reached at gayle.c.thompson@medstar.net.

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