It Takes a Village: Transitional Care, an Interprofessional Collaborative Effort

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ABSTRACT

This study explores reducing patient safety events, improving patient and employee satisfaction, and increasing collaboration between units through the implementation of a standardized handoff tool.

BACKGROUND

The Joint Commission (2012) estimates that approximately 9% in nursing; 5% in OB, and 46% within other services such as anesthesia, emergency medicine and radiology, were directly related to miscommunications among healthcare providers and healthcare consumers. The CRICO group identified 7,149 cases in which communication failures contributed to patient harm with "communication challenge" as the sentinel attribute. This results in an estimated 644 medical error cases in nursing-related services alone.
This community hospital attempted to implement a standardized hand-off tool. However, due to self-reported issues by staff such as complexity, non-customization of the tool, and inconsistency; the process caused increase anxiety and dissatisfaction among staff and patients. Patient and staff satisfaction plays an integral role in patient outcomes and quality of patient care.

PURPOSE

The purpose of this project was to create a unique hand-off tool between two units (Peds ER & PICU) to improve communication and transition of care between these identified units.

METHOD

The community hospital is a 464 bed acute care level I trauma facility located in South Florida that consists of an adult hospital and a children's hospital. The children's hospital consists of two pediatric floors, a pediatric oncology floor, a pediatric intensive care unit, a pediatric inpatient rehab unit and a pediatric emergency room. On average, the children's hospital alone admits 5,000 patients a year.
Root cause analysis identified that improper hand-off between two units created a substantial patient safety event despite using the standard SBAR:

a. Missed patient information
b. Missed orders
c. Communication breakdown between units
d. Patient safety affected
e. Employee inter-unit trust/relationships affected

At the time of this publication, the hand-off tool from Peds ER to PICU has been piloted in this community hospital.

RESULTS

From this, a unit specific hand-off tool was created for what can be known as one of the first transitions in the children's hospital, the transition between the pediatric emergency room to a higher level of care, the pediatric intensive care unit or PICU. Multiple surveys and meetings with the community hospital's leaderships and stakeholders (key administrators, quality improvement team, physicians, nurses, allied health services, etc.) was required to create the Specialty Area hand-off tool from Peds ER to PICU.

FIGURE: PEDIATRIC SBAR TOOL

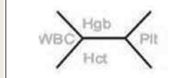
S — Situation

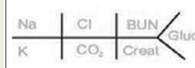
Patient:_____ Date:_____ Room:_____ Time:_____
Chief Complaint:_____ Diagnosis:_____
Isolation: ❑Contact ❑Droplet ❑ Airborne
Home/Current Medication:_____

B — Background

Height:_____ Weight:_____ Allergies:_____
Vital Signs: T:_____ P:_____ R:_____ BP:_____ O2 Sats:_____
Past Medical HX:_____
Last meal: _____ Last Void:_____
*Past Surgeries:*_____

A — Assessment





pH:_____
Lactic Acid: _____
❑ Blood Cx
❑ Urine Cx

Respiratory: ❑ WNL ❑O2 Mode:_____ Amount:_____
❑ Trach ❑ ETT ❑ Cuffed Size:_____ Taped at:_____
*Vent: FiO2:*_____ *Peep:*_____ *TV/PC:*_____ *PS:*_____ *IMV:*_____

Cardiovascular: ❑ WNL ❑ Murmur Rhythm:_____
IV Access ❑PIV ❑PICC ❑PORT ❑Central Line ❑A-line
Site Fluid Rate

Neurological: ❑ WNL ❑ Seizure precautions GCS: _____
❑ Confused ❑Combative Neuro Checks: Q_____hr

GI: ❑ WNL ❑ Nausea ❑Vomiting ❑ Diarrhea Last BM:_____
Gastric Tube:_____ Size:_____fr Suction:_____

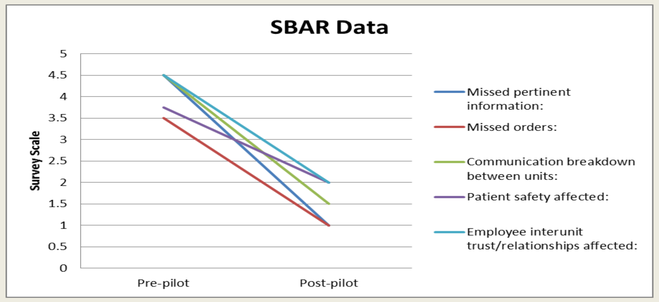
GU: ❑ WNL ❑ Incontinent ❑ Foley Size:_____fr

Psycho/social:_____

R — Recommendations

Review Physician Orders: _____/_____ ❑Physician Handoff
Antibiotics: ❑ Y ❑ N Given: ❑ Y ❑ N Time:_____
Immediate Needs:_____

TABLE: SBAR DATA



DISCUSSION

Transitional care is considered a set of actions that will guarantee the coordination and the continuity of care as patients are transferred between different levels of care (Wee, et. at., 2014). A hand-off tool contributes to proper transitional care and greatly aids in providing concise and objective report on patients' status. Inconsistent report amongst two units can have medical, nursing care (especially patient safety) and social implications. The staff in the different units may begin to feel it impacting the relationships that they have with each other. Trust can become lost during this and the satisfaction of the employees will begin to decrease (Eberhardt, 2014). Multiple research reports that hospital employee satisfaction has correlating effects with patient health and safety outcomes.

CONCLUSION

Miscommunication begets misinformation. Taking into consideration CRICO's (2015) reported data on medical error with injuries due to miscommunications within nursing services (which is 9%); hypothetically, if this concern is not mitigated, there will be 450 projected pediatric patients (pp) (out of 5,000 pp) a year who will suffer medical error related injuries from this community hospital. When adequate and concise communication occurs, important information is not missed. If a hand-off tool is not used, the missed information can lead to an extended stay in the hospital. A severe or sentinel event could occur as well. Any event that requires additional care is a financial burden to the patient, facility and community on many different levels. Extra services are needed as well as extra supplies. Depending on the severity of the event or issue that is caused, additional staff may be needed. In addition, readmissions can arise depending on the harm done. All of this is from miscommunication or lack of communication (Wee, et.al, 2014).

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