Improving Nursing Shift to Shift Handover in Paediatric Intensive Care

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Who Are We?

3 Canadian paediatric academic health science centers

BC Children’s Hospital

Winnipeg Children’s Hospital

The Hospital for Sick Children
Background

• >60% of sentinel events involve breakdown in communication; **50% of these occur during handoff** JCAHO, 2005

• Structured communication is now an industry standard e.g. use of SBAR, checklists

• All 3 sites had similar issues including:
  - Inconsistencies in quality of information provided during nursing shift to shift report leading to patient harm & near misses
  - Double checks required at handoff inconsistently completed e.g. review of infusions & orders, transcription of medications, visualization of patient
  - Time taken to provide report varied from too little to too long
  - Errors & adverse events from one shift continued onto the next because they were not picked up during nursing handover report
Why is Handover So Risky?

- It involves a transfer of accountability resulting in an interruption in continuity of care
- Critical patient information is communicated
- There is variability in giver and receiver competence and needs
- Interruptions and distractions occur frequently
- It is usually completed at a busy time – sense of urgency, multiple distractions
- It must be completed in a defined period of time
Our AIM

Improve staff nurse shift to shift report by using a structured report tool to reach the following goals:

• Reduce unnecessary interruptions
• Reduce average report time
• Improve the flow of nursing report
• Reduce missed or inaccurate information
What Did We Do?

• Structured & standardized nursing report tools were developed & implemented at all 3 sites
• Varying methodologies were used including:
  ➢ Toyota Lean – Rapid process improvement week
  ➢ The Model for Improvement – Use of PDSA cycles to test changes
• Tools & methods were shared & customized for each site
Results

Use of Handoff Tool

• One site reduced the % of reports that were interrupted from 93% to 38%

• Average report time remained relatively unchanged
**Results – Flow of report**

**BEFORE**
This diagram shows flow of report without use of report tool

**AFTER**
This diagram shows flow of report with use of report tool
Results

Nursing Report Defect Rate

Note: Data reflects defect rate for all reports during study period including when the report tool was not used.
Lessons Learned

- Use of focused rapid process improvement week with dedicated staff resources helped to maintain momentum.
- The people who do the work should be the ones to design & implement the change in practice for e.g. the frontline nursing staff.
- Staff engagement is enhanced by involving staff in testing the report tool and making changes based on their feedback.
- Pure standardization of report can be challenging due to patient specific differences however use of a structured tool can reduce variation between practitioners & improve the accuracy of report.