

HOSPITAL CHARACTERISTICS

## SAINT VINCENT HEALTH CENTER

- ▶ Erie, PA
- ▶ 417 beds
- ▶ [www.saintvincenthealth.com](http://www.saintvincenthealth.com)

### S . T . E . E . E . P .



#### SAFE

Patient safety is increased by a complete and accurate communication tool.



#### EFFECTIVE

The communication tool is evidence based.



#### EFFICIENT

Standardized communication lets everyone know what is needed

## IMPLEMENTING I-SBAR

### The Problem

Communication is listed as the leading factor in the root causes of sentinel events as reported to the Joint Commission for the years 1995 through 2005. As a result, in 2008, the Joint Commission added National Patient Safety Goal 2E—"Implement a standardized approach to 'hand off' communications, including an opportunity to ask and respond to questions."

Many medical errors can be prevented through proper communication particularly among the various nurses who encounter a patient during their hospital stay. We concluded through observation and an informal nurse's survey that none of the staff nurses had a standard that they followed for giving a report to the next caregiver.

Patient safety is a major focus here at Saint Vincent and the information we collected proved that it was necessary to develop a standard "hand-off" tool to decrease the chances of a communication error and therefore decrease the chances of an error occurring. We were challenged in the operating room to not only develop the best patient safety guidelines, but to also develop the proper documentation standard for regulatory compliance.

### The Solution

The development of a standard communication process started with information gathering from staff members at all levels of care within the surgical suite. We chose to utilize a tool developed by the Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality called TeamSTEPPS. It is an evidence-based system to improve communication and teamwork.

Additionally, the I-SBAR mnemonic, developed by Kaiser Permanente of Colorado, was used as the base for the new hand-off tool.

The development of the printed patient record was changed to assist in proper communication of patient data. That form was completed through collaboration of the nursing staff and the technological staff to make the data flow in a standard format used every time the hand off report is given. After many revisions, a final format was developed and an educational PowerPoint presentation was given during a unit-based in-service prior to the initial change. The format and the principles have been incorporated into the orientation of all new registered nurses. The surgical patient benefits from this now standardized, concise, complete, and accurate report that is given from the print out from all three areas of the surgical suite.

### Results

Prior to this project, we found through observation and informal survey of the nurses that none of our perioperative nurses followed any type of standard when giving report to the next caregiver. On an average, the Saint Vincent Health Center surgical suite processes 500 to 600 surgical patients a month. During the surgical experience, a "hand-off" of care is

## TEAM MEMBERS

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given a minimum of three times per patient, between the admission area, intra-op and the post anesthesia nurse. That equals 1,500 to 1,800 times where there is an opportunity for a “break in communication” to occur every month. This does not take into consideration the amount of time the care of the patient is transferred to another caregiver for lunch relief or end of shift relief. It would be difficult to measure how many communication errors have been prevented since the development of the nurse’s notes that are printed in the standard I-SBAR report sheet. The only we know for sure is that is that the information that is relevant to the patient’s care is printed 100 percent of the time in a standard format that is used to give all hand off reports for every surgical patient.