Reducing the Risk of Patient Harm by Improving Handoffs Via Group Chat

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Introduction and Problem:
Patient handoffs are a well-known time of risk. A complete handoff should contain: critical patient information, clear changes in responsibility and provide the ability to ask questions.

Aggregated incident reporting data in our hospital showed failures in handoff communication contributed to some patient harm events and near miss safety events. We wished to reduce handoff related harm.

Measurement:
In CY 2021-2022 we aggregated incident reports and showed that there were 147 handoff related communication failures, some which led to, or nearly caused, patient harm.

Understanding the root causes of these failures required Gemba observations with transportation services, root cause analysis and mapping patient transfers and handoff processes within our organization.

Analysis:
Statistical analysis was not completed however a taskforce comprised of nursing leadership, quality, risk/ safety and transportation services interviewed staff members, went to the Gemba in various departments such as the ED and MRI and observed the paper handoff process, reviewed literature best practices, process mapped and brainstormed potential solutions.

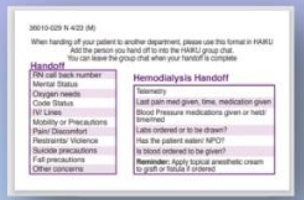
Implementation:
Our paper handoff tool that was called 'ticket to ride' was not seen as value-added- leading to time and paper waste. We implemented a group secure chat texting process, retrievable in the patient's record and distributed standard work critical information badges.

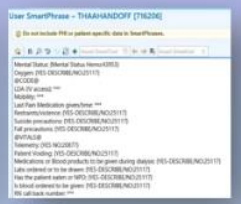
Results/Discussion
Since June 2023 we have had only 15 handoff incident reports. Small tests of change, standard work, strong change management and having a nursing director own and advocate for this change was critical to its success. We continue to meet monthly and retrospectively audit admissions for handoff requirements. **Other organizations that have secure chat features could consider a similar approach to address handoffs.**

Learning Objectives:

1. Handoffs are a common cause of communication failures and can lead to patient harm. Developing strategies that standardize critical information exchanges that is value-added and retrievable is doable.
2. Critical information and responsibility, and documentation of such, should be transferred among departments when patients are moving between them. This should include transporters as a part of the care team.
3. A secure group chat is one way to ensure handoffs happen consistently as they are retrievable in the medical record.

☑ Standard Work including Wearable 'Badge Buddy', EPIC Smart Phrase and Report expectations





☑ Process map of pilot area – MRI

☑ Example of Group Chat Texting Process that is retrievable in EMR