

## Introduction

Measuring and understanding the culture of safety is not only a federal and regulatory mandate, but an important activity to improve the safety of the organization for both the patients and the staff

Our organization uses the AHRQ Culture of Safety Survey 2.0 to measure our culture of safety across all five hospitals

## Background

In 2023 all five hospitals saw a drop from 2021 in the scores about “important patient care information being left out during shift change” as well as “when transferring patients from one unit to another, important information is often left out”

Poor communication among healthcare professionals is a significant factor contributing to patient safety failures, with studies indicating it's a leading cause of medical errors and adverse events. Communication failures can result from written, verbal, electronic and non-verbal communication

## Analysis

Through analysis of top opportunities from the Culture of Patient Safety Survey reports, the opportunity to improve hand-off communication during shifts was identified

Although not statistically significant and varying by facility, there was an aggregate 3% decrease in the score about important information being left out during shift change as well as a 1.4% decrease in transferring patients and important information being left out.” between 2023 from 2021

## Actions

Senior Leadership made improving communication about patients through improving hand-off reports an organizational-wide goal

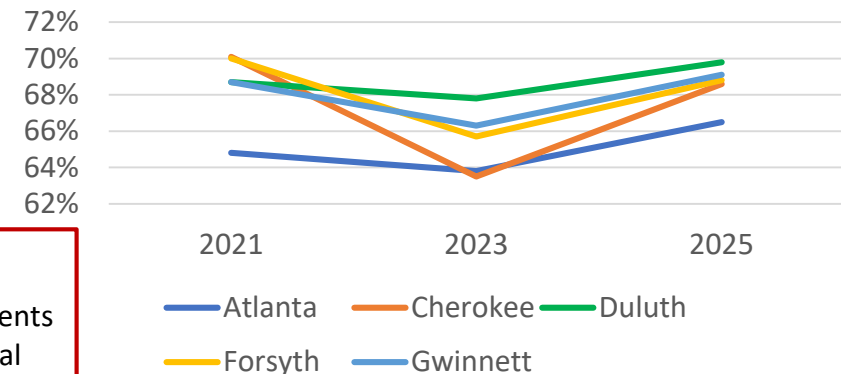
Prioritization began with the acute care (medical-surgical/oncology) units and was closely followed by the Women’s Services departments going across the entire continuum. Then hand-offs from Emergency Department to acute care departments were addressed.

Utilizing the EMR system and front-line staff feedback, a new printable hand-off tool was developed to ensure that the staff had key, standardized information for their handoffs for shift-to-shift reports or transferring patients.

## Outcomes

Staff satisfaction was achieved during implementation and throughout the quarter after implementation. There were no complaints from staff and our processes successfully passed triennial surveys and resulted in improved scores in 2025, 3.2% and 2.2% respectively, slightly above the 2021 scores.

During shift changes, important patient care information is often left out.



## Next steps

The organization will continue to implement improved hand-off processes, beginning with the critical care units, then moving on to surgical-services transitions of care, rehab services, and respiratory care