Beth Israel Deaconess Hospital-Milton

Implementation of the I-PASS Safer Patient Handoff Process

The Problem

Joint Commission Sentinel Event data between 1995 and 2017 strongly confirms that ineffective communication between care providers is a primary contributing factor in preventable patient harm events. Consecutive Culture of Safety surveys at BID-Milton in 2016 and 2017 revealed staff concerns as to the actual/potential risks associated with "Hand-off" communication failures at the hospital.

An effective patient handoff is defined as the transfer of a patient from one staff member to the next in a team-based care approach in providing holistic care to the patient during their hospital stay.

Additional BID-Milton data supported the need for the hospital to re-evaluate its current hand-off processes, i.e., between 1/1/2016- 9/1/2017, a total of 17 safety reports were received from numerous departments where ineffective communication was identified.

Aim/Goal

The hospital's primary goal was to mitigate the risk of patient harm by implementing an effective, resilient, evidence based, standardized "Hand-Off" process throughout the organization. The hospital selected the I-PASS Safer Handoff Bundle (I-PASS) as the tool and method that would most effectively meet the needs of its current patient population and respond to employee concerns. This model incorporates 5 key elements that are deemed essential for an effective hand-off process (**I**: *Illness Severity*, **P**: *Patient Summary*, **A**: *Action List*, **S**: *Situational Awareness & Contingency Planning* and **S**: *Synthesis by Receiver*).

BID-Milton received a $50,000 grant from CRICO to introduce the I-PASS Safer Patient Handoff process at the hospital. This process involved participation in a mentored program provided by Boston Children's Hospital which had a long, established and successful use of this process.

The Team

An I-PASS Steering Committee was formed and consists of a project manager, executive and nursing leadership, Health Care Quality & Patient Safety, Staff Development, Medical Staff and Communications/Marketing representatives. Each member assumed specific roles that ranged from implementation coordination, advisory, champion, educator, communications etc.

I-Pass Team Members

- Ashley Yeats, MD, FACEP: VP HCQ/CI & CMO
- Lynn Cronin, MSN, RN, CNL: VP Nursing/CNO
- Jeannette Currie: CIO
- Alex Campbell, MSN, RN, NE. BC, CPHQ: Director HCQ &PS
- Angela Sims, MBA/ MHSA: Project Manager
- Heidi O'Connor, MD: Medical Director, ICU Intensivist program
- Nick Csikesz, MD: ICU Intensivist
- Daniel Siao, MD: Medical Director, Hospitalists
- Anas Rihawi, MD: Hospitalist
- Tracy Dickerson, PA-C: Chief, Surgical PA.

I-Pass Team Members (cont'd)

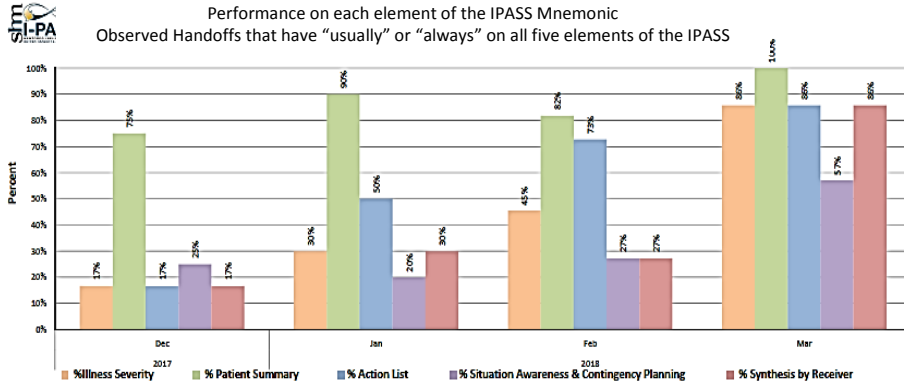
- Alex DiRaimo, PA-C: Surgical PA
- Greg McCormick, PA-C: Surgical PA
- Dawn Zaccaria, MBA, RN: Director, Nursing Ops.
- Karen Stockbridge, MSN, RN: Director, Professional Development (Nursing)
- Ellen Lanza, BSN, RN: Nurse Manager, ICU/2N
- Jena McEachern, BSN, RN – CNC, 2 North
- Adriana Ranalli, BSN, RN: Clinical RN
- Mary Bertocchi, BSN, RN: Nurse Educator
- Robert McCrystal: Director, Communications
- Laureane Marquez: Communications/Public Relations Associate

Interventions

The following interventions were part of a structured, mentored and piloted roll out plan. This involved handoffs between ICU Intensivists/Hospitalists, Surgical PAs and Nursing Staff. Initially an M/S floor was selected for nursing; however this was changed to the ICU to more effectively manage the scope of the project for the pilot.

- Creation of a multidisciplinary I-PASS steering committee with a structured reporting line to the hospital's Board of Directors
- Identification of clinical champions to promote understanding and act as local experts
- Collection of baseline data: Direct observation by trained staff of pre-I-PASS hand off processes to determine the presence or absence of the 5 key components of I-PASS
- Ongoing and regular mentored phone calls as well as onsite visits and steering committee education
- Communication and sharing of I-PASS program activities and progress made to multiple committees and other forums
- Extensive education to key stakeholders as to elements of I-PASS with direct feedback to learners (Included: TeamSTEPPS ©, 1:1 training, didactic presentations, videos, self-directed study opportunities and simulation exercises)
- Development/utilization of communication templates and tools (electronic and paper)
- Post-education and pilot implementation data collection.

Results/Progress to Date



The above data reflects progress relative to hand off communication between surgical PA staff. December 2017 data reflects pre-IPASS implementation performance. Through full adherence of I-PASS, the Surgical PA program saw an increase in the inclusion of the I-PASS elements in their shift-to-shift handoff processes. i.e., an 85% overall improvement was achieved.

Lessons Learned

- Initial plan to involve larger M/S floor was problematic due to volume of nursing staff (many who float): changed to ICU
- I-PASS model originally developed with focus on medical staff communications. Adapted for nursing staff.

Next Steps

- Further planned pilots in identified areas as a means of spreading and sustaining the I-PASS program
- Ongoing data collection and real-time provider feedback to promote adherence
- Increasing organizational awareness through regular and creative communication strategies.

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