TL9EO – Nurse leaders (exclusive of the CNO) use input from clinical nurses to influence change in the organization. Choose two of the three below: (examples must be different from those provided in TL8)

Provide one example, with supporting evidence, of a change in the nurse practice environment that was influenced by the clinical nurse(s') communication with a nurse leader. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.

Or

Provide one example, with supporting evidence, of a change in the patient experience that was influenced by the clinical nurse(s') communication with a nurse leader. Supporting evidence must be submitted in the form of a graph with a data table that clearly displays the data.

Or

Provide one example, with supporting evidence, of a change in nursing practice that was influenced by the clinical nurse(s') communication with a nurse leader. Supporting evidence must be submitted in the form of a graph with a data.

Example 1: Change in Nurse Practice Environment: Handoff of Care

Background/ Problem:

According to the Joint Commission, "80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off." The commission identified ineffective handoff communication as "a critical patient safety problem in health care." Handoff is the communication between a sending clinician and a receiving clinician when the care and responsibility of a patient or group of patients is transferred from one caregiver to another. With the risk of incomplete, inaccurate or omitted knowledge or information sharing, care transitions present a very vulnerable point in patient progression/treatment.

Describe the problem(s) that exist(s) in the organization:

Prior to the implementation of Epic, our electronic medical record (EMR) system, handoff of care (HOC) was traditionally conveyed via verbal report between practice settings over the telephone. With the implementation of the EMR and reliance on new technology, verbal reports during transfers became less frequent, and clinicians began reporting gaps in important information, lack of opportunity to ask questions and unsafe anticipatory preparation prior to patient transfers. By the spring of 2012, our nursing

practice environment surrounding handoff of care was being described by nurses as suboptimal for patient safety.

Nursing staff concerns were expressed during routine nursing leadership forums, as well as during our PNSO President rounds in the inpatient units and in the emergency department during the summer of 2012. The PNSO President and President-Elect worked with their coach, Holly Hintz, MSN, RN, NE-BC, Director of Nursing Governance Programs, to determine next steps in channeling this feedback to nursing administration, our CNO, and the Nursing Cabinet.

Evidence of HOC-specific safety challenges was demonstrated in results of the organization-wide survey on patient safety culture that was conducted by the Agency for Healthcare Research and Quality (AHRQ) in December 2012. Scores from this survey explicitly identified HOC as an area for significant organization focus. This underscored the anecdotal feedback from frontline nurses that indicated we needed to strengthen this part of the day-to-day practice environment.

Table 1 and Table 2 below illustrate nursing feedback from the AHRQ Hospital Survey on Patient Safety Culture, which confirmed the need to improve patient transitions between providers.

TL9EO Table 1. Nursing Feedback, Hospital Survey on Patient Safety, Question 3: Things "fall between the cracks" when transferring patients from one unit to another

Strongly Disagree/ Never	Disagree/ Rarely	Neither/ Sometimes	Agree/ Most of the Time	Strongly Agree/ Always	**Percent Positive**	**Percent Negative**
2%	18%	31%	39%	9%	**20%**	**48%**

TL9EO Table 2. Nursing Feedback, Hospital Survey on Patient Safety, Question 7: Problems often occur in the exchange of information across Medical Center units

Strongly Disagree/ Never	Disagree/ Rarely	Neither/ Sometimes	Agree/ Most of the Time	Strongly Agree/ Always	**Percent Positive**	**Percent Negative**
3%	22%	36%	34%	5%	**25%**	**38%**

In response to clinician reflections and validating AHRQ survey results, and the ongoing review of patient safety issues presented at our institutional Patient Safety Committee meeting, improving our nursing practice environment around the handoff of care process became a major focus for our nursing organization in 2013.

Goal statement:

Improve nursing staff perception of the adequacy/safety of hand-off communication utilizing the Joint Commission Targeted Solutions Tool (TST) for Hand-off Communications.[1]

Description of the Intervention/Initiative/Activity(ies):

In **January 2013**, the organization-wide executive-level Patient Safety Committee assigned a work group to standardize HOC across all settings and all disciplines. The standardized communication format of IDEAL was identified as the standard method for the organization, and each discipline was tasked with incorporating it into a consistent handoff process.

The elements of the method are:

- Identify – Patient name and medical record number or date of birth; and physician name
- Diagnosis – Diagnosis and current condition
- Events – Recent events / changes in condition or treatment
- Anticipated – Anticipated changes in condition or treatment, what to watch for in next interval of care, contingency plans
- Leave – Leave time for the opportunity to ask questions and clarify information

As a nurse leader, Hintz partnered closely with Sarah Craig, MSN, RN, CCNS, CCRN, Advanced Practice Nurse 1-CNS, and Suzanne Fuhrmeister, MSN, RN-BC, ACNS-BC, Advanced Practice Nurse 1-CNS, the Chair and Vice Chair of the PNSO Clinical Practice Committee (CPC), to plan the project approach on behalf of nursing in collaboration with the interprofessional workgroup. In September 2013, Hintz, Craig and Fuhrmeister created a nursing Handoff of Care Steering Committee to lead this practice environment change across all settings. Nurse leaders Joel Anderson, MSN, RN, CNL, Director for Adult Acute Care, and Andrea Caulfield, MSN, RN, FNP, NEA-BC, Director for Adult Critical care and Inpatient Heart, and Trish Higgins, MBA, BSN, RN, Director of the Emergency Department, played key roles in helping staff evaluate and redesign processes. They supported the change management process needed to standardize the new nursing practice environment of safe handoffs. In addition to serving on the committee, they sought ongoing feedback from clinical nurses in their operational areas and reviewed quality report data to better understand system barriers and the concerns of nurses in their chain of command.

[1] The Joint Commission Center for Transforming Healthcare. (June 2012). *Targeted Solutions Tool (TST)™ for Hand-off Communications.* http://www.centerfortransforminghealthcare.org/tst_hoc.aspx

From the beginning, best practices from peer institutions and the literature guided the nursing effort. Hintz, Craig and Fuhrmeister chose the Joint Commission Targeted Solutions Tool (TST, which provided a great fit for the needed changes. In particular, the use of the TST for measuring pre- and post-implementation data provided a consistent approach to harvesting clinical nurse feedback and tracking our progress.

Feedback from clinical nurses was highlighted in framing the needed changes, calibrating our success with the new standards and continuing to address systems issues. The phases of this massive change effort are described in the timeline below.

In **June 2013**, Patient Safety Department Director Rebecca Hill presented to the PNSO CPC the priority and concerns based on Patient Safety Committee trended cases. This provided the foundation on which the CPC approached changes and tool development used in the process.

In **July 2013**, the CPC passed a practice standard that designated verbal communication as the expected clinician-to-clinician hand-off method. In order to make this easy to do, and in response to clinician feedback, the CPC launched the development of an auto-populating Epic tool to include the relevant points to be shared by clinicians during handoff.

In **August 2013**, an online survey was used to gather feedback from more than 50 nurses (a combination of unit-based practice chairs and clinical nurses) to determine specific HOC content to be included in the Epic tool. Nurse Informaticist Laurie Brock, MSN, RN, shepherded this work through the requisite committee and Epic reviews. The draft tool was demonstrated in the CPC and regional practice committees to gather clinical nurse feedback, which informed further revision. The tool was also added to the Epic “Playground” testing environment so that a variety of clinical nurses could interact with it and provide feedback.

Through these feedback processes, a consistent core of clinical content was identified. The final HOC tool included a succinct format using the IDEAL format to guide consistent verbal report between clinicians. The information in the report continuously refreshes with updated clinical data so that it provides up-to-the moment review of the patient’s picture and anticipated needs.

To further standardize the hand-off method, the report was designed to pop up automatically when opening both the admission and transfer navigators in Epic so it meets the clinician’s expressed requirement to be easy to find and use. Clinicians expressed satisfaction that this functionality enabled them to preview the hand-off profile prior to receiving report in order to plan.

In **August 2013**, the CPC approved a Handoff of Care nursing procedure as a permanent resource for clinicians.

Having the process established and a tool developed, the CPC was ready to present its plan to the organizational Patient Care Committee (PCC) that was overseeing the interprofessional HOC improvement efforts.

In **September 2013**, Hintz, Craig and Fuhrmeister presented the plan for improvement to the PCC and received approval to move forward.

To enable evaluation of the new processes, Hintz, Craig and Fuhrmeister coordinated an audit process using the Joint Commission TST to measure the perception of sending and receiving nurses. To establish a baseline of the pre-implementation state, 140 handoffs were audited over two weeks in **October 2013** across many inpatient settings during different shifts and days. Clinical nurses Scott Austin, RN, Clinician III, and Stephanie Hedrick, RN, collected audits. In the process of conducting the audits, Austin and Hedrick also collected comments from clinical nurses. These comments were instrumental in designing an education plan.

In **November and early December 2013**, Hintz, Craig and Fuhrmeister presented updates and plans to the PNSO Cabinet, regional practice committees, nurse education coordinators and nurse managers. This included the results of the pre-implementation audits, general comments from clinical nurses, and a preview of the newly developed tool and resources.

Staff education began in **December 2013** for the upcoming HOC changes. Education included:

- Computer-Based Learning module developed for all RN staff and new hires featuring a video with nurses giving/receiving HOC
- Announcements placed on the EMR screen savers
- IDEAL badge hangtag distributed as a reference
- Unit / area manager information packets / responsibilities provided during nurse manager meeting
- CPC leadership conducted focused rounding to reinforce education. All inpatient units and the emergency department were visited
- Practice News articles in this period reinforced the coming change

The new HOC process was implemented on **January 6, 2014** in the emergency department, acute care, ICUs and procedure areas. CPC/HOC Steering Committee leadership rounded repeatedly on units for several weeks to gather feedback, answer questions and guide use of the Epic tool. Support was provided by these clinical leaders, and they were able to field staff feedback, which in turn drove issue identification and problem-solving. During the immediate post-implementation phase,

some minor revisions were made based on clinical nurse feedback and were facilitated by Laurie to expedite changes.

In addition to ongoing collection of clinical nurse feedback via periodic online surveys, nurse leaders Higgins, Anderson, and Caulfield continue to follow up on a weekly basis by reviewing “hand-off issues logs” that contain feedback from frontline staff and shift managers involved in handoffs that do not meet the standards for timeliness, completeness, etc. These logs are kept at the unit desks in the emergency department and adult acute care units. Directors review the logs weekly with managers to reinforce staff’s use of the standards to facilitate safe practice. The CPC chairs have transitioned some of the operational issues, such as this one, to the directors for follow-up, as the HOC project has become integrated into daily practice.

Post-implementation audits were conducted in **March, May and July of 2014** using the TST.

Participants:

TL9EO Table 3. Participants, Hand-off of Care Steering Committee

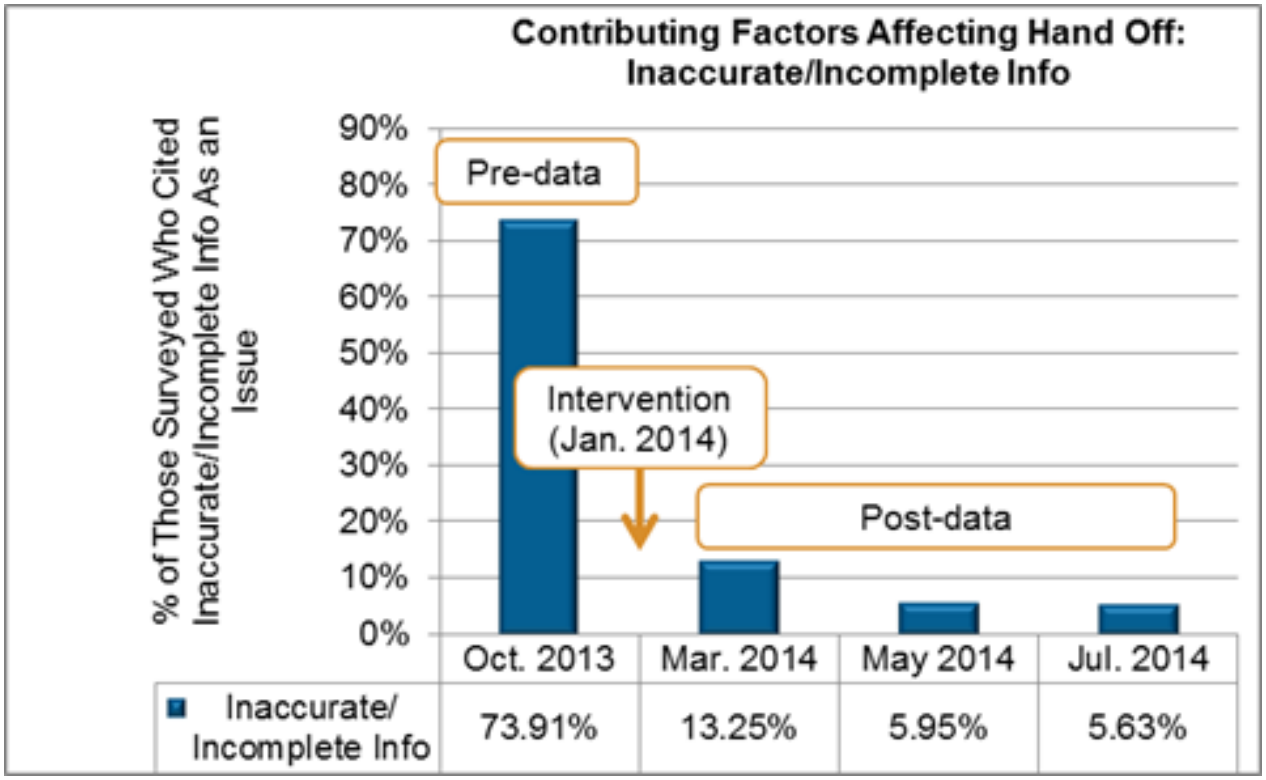
Name	Discipline	Title	Department
Brenda Barrett	Nursing	Nurse Manager	5 East
Joel Anderson	Nursing	Director, Nursing Adult Medical-Surgical Care	Patient Care Services
Rebecca Hill	Administration	Director of Risk Management & Patient Safety	Risk Management
Sarah Craig	Nursing	Advanced Practice Nurse 1, Clinical Nurse Specialist	4 West
Michelle Longley	Nursing	Advanced Practice Nurse 2, Nurse Practitioner	3 East
Suzanne Fuhrmeister	Nursing	Advanced Practice Nurse 1, Clinical Nurse Specialist	4 Central
Scott Austin	Nursing	Registered Nurse, Clinician III	3 West
Stephanie Hedrick	Nursing	Registered Nurse	ED
Stephene Hertwig	Nursing	Registered Nurse, Clinician III and PNSO Critical Care Practice Committee Chair	MICU
Eleanor Bergland	Nursing	Registered Nurse, Clinician III	PACU

Cynthia McCaskill	Nursing	Registered Nurse, Clinician III and PNSO Procedural Area Practice Committee Chair	SAS
Kitty Deane	Nursing	Registered Nurse, Clinician III Ambulatory and PNSO Ambulatory Nursing Committee Chair	Endocrine Clinic
Holly Hintz	Nursing	Director, Nursing Practice and Research	Office of Nursing Governance Programs
Sandy Neumayr	Nursing	Nurse Manager	PICU
Joyce Thompson	Nursing	Nurse Manager	Inpatient Women's Services
Andrea Caulfield	Nursing	Director, Nursing, Adult Critical Care and Inpatient Heart	Patient Care Services
Trish Higgins	Nursing	Director, Emergency Department	ED
Laurie Brock	Nursing	Nurse Informaticist	Electronic Medical Record
Nancy Pierce	Nursing	Registered Nurse, Clinician III	Operating Room
Nancy Addison	Nursing	Registered Nurse, Clinician IV	Pediatric ICU
Ann Rebera	Nursing	Nursing Education Coordinator 2	Nursing Education Services

Outcome(s):

Using the Joint Commission's TST to periodically measure sending and receiving nurses' perceptions of the adequacy and safety of hand-off communication, as of July 2014, we have seen improvements on all of the TST's indicators since implementing the IDEAL Handoff of Care framework. One of the common defects listed on the TST that clearly impacts safe handoff, "Inaccurate/Incomplete Information," needed the most improvement pre-implementation, showed substantial improvement shortly after the implementation of IDEAL, and has shown the greatest improvement margin to date post-implementation (Figure 1). The CPC continues to monitor TST assessments, clinician feedback and results of the AHRQ Patient Safety Survey to evaluate HOC.

TL9EO Figure 1. RN Perceptions of "Inaccurate/Incomplete Information" as a Contributing Factor Affecting Hand-Off Quality (Oct. 2013-July 2014)



Survey Tool: The Joint Commission's Targeted Solutions Tool™ for Hand-Off Communications

Example 2: Change in Nursing Practice: Family Presence in Resuscitation. Clinical Nurse: Dea Mahanes, Nurse Leader: Andrea Caulfield

Background/Problem:

Research demonstrates that practice environments that offer family members the option of being present during resuscitation are beneficial and the practice has no adverse effect on staff performance. Both a formal process for providing family support during the resuscitative process and use of a designated facilitator are supported by the literature.

In April 2012, Alexandra Bandy, MSN, RN, CCRN, CEN, CNL, RN Clinician III from the emergency department, approached CNO Lorna Facteau to discuss the benefits of offering Family Presence During Resuscitation (FPDR). Facteau knew that Dea Mahanes, MSN, RN, CCRN, CCNS, CNRN, Advanced Practice Nurse 3-CNS, was interested in this topic, and she brought the two clinicians together. Together Bandy and

Mahanes reviewed the FPDR guidelines from the Emergency Nurses Association and the American Association of Critical-Care Nurses. They agreed that the concepts of family integration were important to family satisfaction and overall patient care. They presented their plan to nurse leader Andrea Caulfield, MSN, RN, FNP, NEA-BC, Director of Nursing Adult Critical Care and Inpatient Heart, who added them to the June Critical Care Subcommittee meeting agenda. The subcommittee was interested in the creation of a practice guideline. As part of the critical care division's efforts to support patient and family involvement in care, Caulfield proposed that a group be formed to develop and implement a FPDR program to facilitate this change in practice to increase the percentage of codes in which family presence during resuscitation is offered.

Goal Statement:

Increase the percentage of codes in which family presence during resuscitation is offered.

Description of the Intervention/Initiative/Activity(ies):

In June 2012, an interprofessional workgroup sponsored by Caulfield and led by Mahanes and Lori Lute, NP, was formed. Caulfield empowered the clinicians to build a FPDR practice guideline. She included FPDR on the Critical Care Subcommittee meeting agenda and facilitated progress as obstacles to development were identified. The initial emphasis of this work group was to facilitate the practice of family involvement in FPDR throughout the critical care division.

In November 2012, the FPDR work group developed a proposal, based on available research and information from professional organizations, to support the FPDR practice through the use of a designated Family Support Facilitator (FSF). FSFs are typically social workers or chaplains who receive specialized training in assessing families to determine if an offer of FPDR is appropriate, and support families during a code event regardless of whether or not FPDR occurs.

However, the work group noted that the schedules of chaplains and social workers did not readily support the 24/7 coverage that the FPDR program needed to be fully implemented. Mahanes connected with Nurse Leader Scott Croonquist, MSN, RN, NEA-BC, Associate Chief Nursing Officer. Among other responsibilities, Croonquist oversees the role of the nursing supervisors. Under Croonquist's leadership, the nursing supervisors who are present during the off-shift times were trained as FSFs and integrated into the program. A response system was developed that enables prompt notification of the FSFs when a code occurs. More than 60 individuals have completed FSF training.

With the FSF training completed, Mahanes developed an FPDR practice guideline, which was piloted in the medical intensive care unit (MICU) in March 2013. The

preliminary feedback on the MICU trial was positive. As a result, the practice guideline was implemented throughout all of adult critical care, the emergency department, and the pediatric intensive care unit on May 6, 2013. A multimodal educational approach was rolled out to meet the unique needs of the nurses, respiratory therapists, health unit coordinators and patient care assistants, as well as all levels of physician staff and other licensed independent practitioners in the various practice settings. The training consisted of a combination of education sheets, presentations at staff meetings, brief in-service trainings, informational fliers and FPDR reminder tags on desk phones.

The evaluation included process measures such as tracking the practice of activating the FSFs and clinical documentation in Epic stating that family presence was offered. Staff perception was an important element of success. Initial training to communicate the benefits of FPDR provided a foundation of understanding and engagement in the practice. Surveys were conducted to evaluate staff support of routinely offering FPDR.

Participants:

TL9EO Table 4. Participants, Family Presence During Resuscitation Pilots

Name	Discipline	Title	Department
Andrea Caulfield	Nursing	Director	Adult Critical Care and Acute Heart
Scott Croonquist	Nursing	Associate Chief Nursing Officer	Patient Care Services
Dea Mahanes	Nursing	Advanced Practice Nurse 3-Clinical Nurse Specialist	NNICU
Lori Lute	Nursing	Advanced Practice Nurse 1-Nurse Practitioner	NNICU and Acute Cardiology
Chris Popish	Social Work	Supervisor, Clinical Social Work	Social Work
Nancy Addison	Nursing	Registered Nurse-Clinician IV	PICU
Rachel Anderson	Nursing	Advanced Practice Nurse 1-Nurse Practitioner	Lung Acquisition
Susan Aronhalt	Social Work	Clinical Social Worker	Social Work
Cheri Blevins	Nursing	APN2-CNS	MICU
Lanna Buehler	Nursing	Registered Nurse Clinician II	ED
Sarah Easter	Nursing	Registered Nurse Clinician II	STBICU

EB Enfield	Nursing	Advanced Practice Nurse 1-Clinical Nurse Specialist	CCU
Elizabeth Gay	Physician	Assistant Professor of Medicine	MICU
John Gilday	Nursing	Registered Nurse Administrative Coordinator	Life Support Learning Center
Luella Glanzer	Nursing	Registered Nurse Clinician III	STBICU
Daryl Gress	Physician	Associate Professor of Neurology, ACMO Critical Care	NNICU
Elizabeth Guastella	Nursing	Registered Nurse Clinician I	MICU
Jenny Hamby	Nursing	Nursing Education Coordinator II	ED
Melvin Janzen	Chaplain	Chaplain	Chaplaincy Services & Pastoral Education
Richard Stairhime	Respiratory Therapy	Supervisor of Pulmonary Diagnostics & Respiratory Therapy	Respiratory Therapy
Kristina Yoder	Nursing	Registered Nurse Clinician I	MICU
Jill Delawder	Clinical Nurse Specialist Student	Student	University of Cincinnati School of Nursing

Outcomes:

As a result of this practice change, the percentage of codes in which FDPR was offered improved from 0% in 4Q12 to 100% in 1Q14.

TL9EO Figure 2. Percentage of Codes Where FPDR Offered (4Q12-1Q14)