



KEY POINT SUMMARY

OBJECTIVES

To determine whether the implementation of this hand-over communication process and tool is effective in improving communication and decreasing patient care errors related to communication among healthcare providers of all disciplines.

A Novel ICU Hand-Over Tool: The Glass Door of the Patient Room

Wessman, B.T., Sona, C., Schallom, M., 2017 | *Journal of Intensive Care Medicine*. Volume 32, Issue 8, Pages 514-519

Key Concepts/Context

The Institute of Medicine has identified poor communication among the patient care team as one of the most common causes of serious errors in patient care. There was a desire in this organization to create a culture of team-oriented continuity of care by changing the mindset of handoff reporting to handover reporting communication among multidisciplinary care team members on key aspects of the patient's daily plan of care. They developed a communication tool that included key areas of care (tests, care goals and progress toward those goals, treatments, and consultation recommendations) and printed the topic areas on the glass door of the patient room. The information was updated regularly throughout the day/night so that the most current information on patient status was available any time for rounding by various care providers, specialists, and consultants. The information was also available for viewing by the patient's family.

Methods

The communication improvement project was done at an academic tertiary surgical/trauma 36-bed ICU with an average of 214 admissions per month. They created a template that was embossed on the patient room glass door. The template was divided into three columns; one for each team: day team, night team, and surgical/consultant team, and that included goals for the patient and areas to track such items as lines, antibiotics, ventilator weaning, and deep vein thrombosis screening. The information was filled out throughout the 24-hour period by each of the teams. The information was available to all care providers to review during daily bedside rounds. Patient-identifying information was not included, so there were no HIPPA issues. The authors retrospectively reviewed all ICU safety issues over a four-year period; two years before implementation of the glass door communication tool and two years post implementation. The reviewers of these reports separated out all handover communication-related errors. The cohorts of



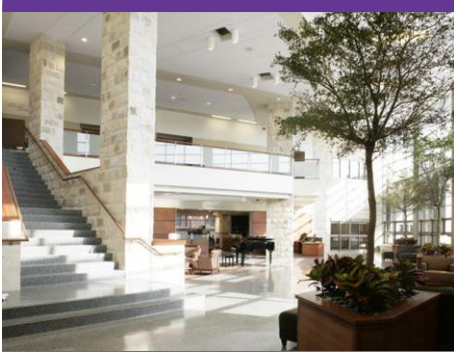
handover communication errors were compared, and an absolute error reduction value was calculated.

Findings

A relative risk reduction of 46.5% is significant and therefore the medical center continues with the tool on the glass door. The strength of the glass door communication tool is the simplicity of the design and implementation that has a direct impact on patient safety and communication. Due to the success of this communication tool, it has been implemented in ICUs across their healthcare system. During a hospital review, the Joint Commission recognized this communication tool as a best practice for ICUs. In addition to improving communication within the healthcare team, families have also expressed appreciation for having access to patient information. The design implications of this study are related to whether a large sliding glass door is selected for each patient room, as opposed to using just a large solid door with a big window.

Limitations

The study was based on a pre-/post-intervention format using data from the organization's patient safety error reporting system (SES). The dataset is subject to the weaknesses of a self-reporting system. Bias was removed by blinding the reviewers regarding the intention of labeling an event as a communication error. Communication errors could have been higher and not actually reported in the SES system. There was a change in the physical environment of the unit; it was expanded from 24 beds to 36 beds during the study period. Errors could have been higher if the unit had 36 beds for the entire study period.



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Design Implications

To adopt this type of handover communication approach, the unit must have large sliding glass doors on patient rooms. This tool would have to be considered when decisions are being made in patient room configuration. Templates would have to be decided so that the highlighted areas for reporting can be embossed on the door. Obtaining input on the design from clinical staff is imperative in this design decision. The combination of the glass doors and the communication tool on the glass can be considered a patient safety design intervention.

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