



COLLEGE OF NURSES
OF ONTARIO

ORDRE DES INFIRMIÈRES
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THE STANDARD OF CARE.

Who you know...Safe Transitions in Care

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Objectives

- To provide an overview of the CNO collaborative Transfer of Accountability Knowledge Translation Fellowship
- To support the focus of community nurses on building community capacity during a transfer through the use of stories from the community sector
- To provide information related to key project findings

College of Nurses of Ontario in partnership with.....

School of Nursing, Faculty of Health, York University

Ontario College of Pharmacists

College of Physicians and Surgeons of Ontario

St. Michael's Hospital, Toronto

Sunnybrook Health Sciences, Toronto

Project Goal

To develop knowledge that will improve patient safety outcomes by gaining greater understanding of regulatory requirements associated with the transfer of accountability (TOA) across multiple boundaries of care

CNO Strategic Plan 2005 -2010

Mission: To protect the public's right to quality nursing services by providing leadership to the nursing profession in self-regulation

Vision: Excellence in nursing practice everywhere in Ontario

Objectives:

- Building confidence in nursing self-regulation
- Advancing the use of CNO knowledge

Study Definition: Transfer of Accountability (TOA)

“A patient care transfer, also handoff or handover, is an interactive process of transferring patient-specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the patient’s care”

Methods

3 Phases

- Phase 1 Background and Literature Review
- Phase 2 Data Collection and Analysis
 - 85 interviews utilizing Appreciative Inquiry framework
 - Outreach Consultants
 - CPSO; OCP; St. Michael's Hospital, Toronto; Sunnybrook Health Sciences, Toronto
- Phase 3 Validation of Findings & Implications for Regulatory Framework

Themes

1. Client and Provider Focused
2. Structured Flexibility
3. Independent Collaboration

Client and Provider Focused

“ a stroke patient was transferred from the acute care setting to home. The nursing supervisor came to the home with the PSW to show them what to do during the transfer from bed to chair, etc. The family were present at all times so were able to talk about what happened in hospital as well as the client’s preferences; there was amazing support from the family. The client didn’t need to say ‘do I have to tell you again’. My role as a PSW was to provide ongoing care initially on daily basis so support from family and supervisor were extremely important. The client care was excellent due to involved family and continuity in care by the team of nurses, physios and PSW’s”
(Home Health, PSW)

Client and Provider Focused

“A client was diagnosed as paraplegic post-motor vehicle crash; he was ready to be discharged home. The social situation was a huge issue as the client’s wife had left him after the car crash so friends were helping in the transfer process and care. The friends were included in the transfer from the beginning so that adaptations could be made to the home setting to prepare for discharge; a home assessment was completed by an OT; they built a ramp for access and made other required adaptations to the home setting. Information was provided related to medications, diet, restrictions, link for follow-up appointments. It wasn’t just...‘here’s what you need to do, now do it’; thought was taken to provide information related to the expected outcome.” *(NP, First Nations Community)*

Structured Flexibility

“A client who required pain management was in crisis due to uncontrollable pain. The physician had provided us (*community nurses*) with the back-line number for her office. The community nurse called the physician and discussed the pain crisis; the physician agreed to admit the client to hospital. The nurse called the Community Care Access Center and EMS; the physician met the client at the hospital; the client’s spouse went with client. The nurse sent a written transfer sheet to the hospital with the client, that provided a detailed list of medications and dosages. The client was transferred back home within 48 hours. In my opinion (*community nurse*) the physician was key to this transfer as there was ease in accessing the physician”. (*Home Health Nurse Educator*)

Structured Flexibility

“A palliative care client was being discharged home and was prescribed an IV mixture which needed laminar flow compounding and several days to order ingredients. The client was sent home with sufficient meds to cover the gap. This was not official hospital policy; the communication and arrangements were made through the hospital pharmacist.” (*Ontario College of Pharmacists*)

Independent Collaboration

“Transfer between teams is a key issue within the community. There is a need to give information that the new nurse needs to safely give care to client i.e., current symptoms and history as it applies to current status, any significant social circumstances, etc. that the accepting nurse needs to know. This is often done via a verbal report or voicemail but need to confirm that the receiving nurse received the information” (*Home Health Provincial educator*)

Independent Collaboration

“The client had mental health issues and the family found it difficult to care for the individual in the home setting, to the extent that they were neglectful. When this individual presented to the emergency room there was a link between the community and acute care case managers which facilitated improved care, including hospitalization until the patient’s case history could be reviewed by the capacity board. The effort to improve care for this person involved partnership of various organizations, including coordinated police & emergency medical services to remove the client from the unsafe environment. While the change in care took a month of planning, it was an extremely positive experience for all involved due to team work” *(Community Mental Health Caseworker)*

Independent Collaboration

“ Privacy is sometimes an issue. We value and respect client confidentiality but it may also be a barrier....People need to stop hiding behind the confidentiality/privacy laws and using them as a barrier to not share information. This transfer would have been even better if there was a greater understanding of the role of health workers and parish nurses within the community, including more willingness to share health information with client consent”. (*Parish Nurse, Community*)

Stories told us that transfer...

- Is the most vulnerable time for patient and family; alternate care givers and their involvement in health care guides nurses practice in the home
- Requires you to know your patient and the team on both sides of transfer; Know your resources – what you need, what you have and what you need to get
- Reinforces the importance of effective communication
- Is often about “Who you know”
- Is time consuming; dedicate enough time to the transfer process

Principles

1. *Transfer of accountability is an ongoing process and part of a care journey.*
2. *Involvement of the clients and/or family as active participants in transfer decisions and processes is paramount.*
3. *Transfer of accountability requires systems and processes at point of care.*
4. *The knowledge and skills required for successful transfer of accountability are consistent across all sectors and health care providers.*

Principles

5. *There is a sense of ownership and sustainability when transfer processes are developed at the local level with staff input.*
6. *While knowledge and skill are important in transfers of client care, the use of good clinical judgment in the context of each client situation is a key to successful outcomes for clients, families and care providers.*
7. *Electronic health records have the potential to revolutionize practice; however, more of these tools are needed, and we need more of them soon.*

Principles

8. *It is easier to transfer clients within systems you know and to people you have worked with before – a different skill set is required in a context that is less familiar.*
9. *Given the complex and context-specific nature of transfers and the importance of clinical judgment for client safety outcomes, participants responded that the development of a standard of practice and/or standardized guideline from regulatory bodies to support transfer of accountability in all clinical settings is not necessary nor would it likely be meaningful. Instead, there were reports from the participants that they did indeed incorporate existing standards and other tools into their transfer activities.*

Principles

10. *Organizations and teams are working together to create context specific tools that they own, can evaluate and modify, as required.*

11. *Using this type of interprofessional approach to gain further insights into practice setting realities of health care teams is beneficial and supports the need for regulatory bodies to seek input for their products and services.*

Actions

The findings of this project prompted CNO to review its document “Transferring Clients” for relevancy and applicability. As a result of the project, it was determined that this document should be retired and that nurses should be promoted to build on their existing logical and analytical strengths by reviewing current practice standards and practice guidelines that directly influence the process of transfer of accountability. (e.g. *Confidentiality and Privacy - Personal Health Information, Documentation, and Therapeutic Nurse-Client Relationship*)

Conclusions

1. It is recommended that the CNO continue to provide opportunities for nurses and other health professionals to gain insight into each others' practice environments.
2. It is recommended that CNO continue to support professional accountability through relevant policies, position statements, standards, guidelines and/or other documents to which professionals are legally obliged to adhere throughout their career and to encourage their use by members in their maintenance of continuing competence.

Conclusions

3. It is recommended that CNO continue to encourage its members to demonstrate their professional accountability in coming up with innovative responses and strategies to ensure safe transitions in care.
4. It is recommended that CNO continue to identify interprofessional opportunities to gain insight into practice environments through projects of this nature.

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Outreach Program

Questions

