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Long-Term Care Survey Alert

PATIENT SAFETY ~ Communication Pitfalls At Shift Change Can Gear You Up For Serious F Tags

Make sure caregivers have the info they need to provide safe care.

An F tag is often in the details that no one passed along at shift change -- like the fact that Mrs. Smith has been running low blood sugars or Mr. Jones almost fell this morning when he got out of bed without assistance.

So look for these three common problems and be prepared to shore up your reporting system.

1. Strategies that omit "the rest of the story" for CNAs. "Oftentimes the CNAs give report to the other CNAs," says **Cheryl Field, RN, MSN,** a consultant with **LTCQ Inc**. in Lexington, MA. "But that information is out of context with what the licensed nurse did and knows about the resident for the shift -- for example, the fact that the resident started a new medication or had other physician orders," she says.

2. A sign-off exercise gone rote. Some facilities require the licensed nurse to review CNAs' flow sheets and initial them, says Field. But that "good idea" can turn into an empty gesture if the nurse signs off on the sheets without critically analyzing them. And that can happen if the person gets sidetracked with end-of-shift med pass or crises.

3. A time lag in passing along key info. For example, some organizations do walking rounds where licensed nurses and CNAs exchange critical information about the shift, notes Field. The licensed nurse on the oncoming shift then relays the information to other caregivers, including CNAs. "But there can be a lag time where the nurse gets busy starting the shift and doesn't pass that information along," Field cautions. " And during that time, the CNAs are caring for residents without information they may need."

Consider These Positive Solutions

Your facility can implement a number of strategies to counteract the above stumbling blocks to effective communication at shift change. For one, consider engaging staff in developing a policy/procedure that spells out what information the shift report should contain, including who communicates with whom, suggests **Steve Trosty, JD, MHA,** a risk management expert in Lansing, MI.

Put it in writing: To avoid rote sign-offs of flow sheets, implement a documentation system where a caregiver from each shift includes a note in the medical record that they've discussed the appropriate information, suggests Trosty. The people documenting could also highlight the key issues that staff will be assessing and addressing in the upcoming shift -- for example, the resident had a slightly elevated temp or required more help with ADLs than usual. "Require each staff person to take ownership" for the documentation, advises Trosty.

Tip: Some facilities use a 24-hour report book in which staff document anything they think the next shift should know about a resident.

Give staff some clout: In the spirit of patient safety, a facility might also implement a process where staff starting a shift can ask or even require a caregiver from a previous shift to stay late and provide adequate information to care for the residents, suggests Trosty. Managers would have to monitor that type of strategy to avoid abuses, he adds.

Correlate Negative Outcomes to Inadequate Shift Reports

One way to determine if shortfalls exist in reporting resident information at shift change: Ask the caregiving staff. "Staff

members often are the best people to let you know if they are getting the patient information they need when arriving for their shift," says Trosty.

Another idea: Audit "occurrence/incident reports related to patient/resident care to see if they might be related to handoff issues" at shift change, suggests Trosty. Look for "any trend or pattern" developing on "certain shifts or floors or involving certain personnel -- or certain residents," he advises. "Review these reports to see if errors or near misses are related to information that should have been shared or provided at handoff," he advises.