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Safety in the Intensive Care Unit: Daily Goal Sheet

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Although all patient care settings present safety challenges, observational studies support that intensive care units (ICUs) are among the highest risk due to the number of activities performed, the complexity of those activities, and the fragile health status of the patients (Alansari and Hijazi 2006). A recent qualitative study of intensive care patients found that their overwhelming need was to feel safe (Hupcey 2000). High volume of patient data has long been identified as one of the important factors contributing to errors in ICUs. Extrapolating from previous studies, it is estimated that about 85 000 medical errors occur each day in American ICUs, 24 650 of which are potentially life threatening (Pronovost et al. 2004). Root causes of sentinel events showed that many of these errors are as a result of failure of communication between the physicians and nurses (Donchin 2003). Greater than 50% of the $17-$29 billion national cost associated with these errors is preventable (Studdert et al. 1999).

Daily Goal Sheet

Earlier research on patient safety focused on errors of commission (what we do). However, errors of omission (what we fail to, but are suppose to do) may pose an even greater threat to health. 172,263 deaths could have been prevented in an ICU from failing to use interventions like steroids in sepsis and glucose control among others (Pronovost et al. 2004). Errors of omission cannot be reduced unless the systems of care are changed. Focus on interpersonal communication and use of “smart tools” rather than people, are now accepted as a basic science of patient safety.

A keystone ICU patient safety project was launched in Michigan Health and Hospital Association Keystone Center in 2005. This project designed and implemented unit-based safety programs and daily goals sheets to help eliminate major ICU complications (bloodstream infections and ventilator-associated pneumonia). The daily goal sheet was found to improve communication, teamwork and enhance “situational awareness” in the ICU. It also enhances understanding of the patient care goals for the day. It is used daily by physicians and nurses to improve communication. After implementation of the daily goals sheet, the percent of members who understood the daily goals increased significantly. In addition, ICU length of stay has also decreased. The reduced length of stay translates into space for an additional 670 admissions per year in the 16-bed ICU. Based on a predictive model and data collection from ICU patient safety project participants, between March 2004 and June 2005, the project is estimated to have saved 1578 patient lives, 81 020 hospital days, and $164 534 736 in healthcare expenditures (Clancy 2006).

The daily goals sheet (Appendix 1) is organised into “bundles of care” that are evidence based for ICU patients on ventilators, central lines, and antibiotics. We have added to this form space for documentation of nurses concerns, as it was often a problem of communication between nurses and doctors that lead to adverse events. Moreover, we have added a section for documentation of family concerns that can be filled in by a nurse or a family member. The rounding team should assure accuracy and completeness of this sheet before moving to the next patient. The ability to guarantee accurate flow of information between various disciplines in the ICU is also essential.

The distribution of complex patient information among disciplines is a constant challenge. Taking time to contact each team member individually to inform them of the plan of care leads to lost time. Compilation of the daily action plan for each of the disciplines involved necessitates numerous discussions with colleagues who may have varying degrees of accessibility. This is also true when attempting to contact team members who are in other parts of the hospital or who are absent from the ICU. Primary team and consultation services concerns are also considered in this sheet and space for documentation is provided. Because “Daily Goal Sheets” are records of thought processes and decision making by the multidisciplinary team, we have recommended that they be posted beside the patient's head for high accessibility. Using this approach in the critical care setting provides the team with thoughtful, concise information, enhances efficiency and increases consistency of care, thereby reducing errors and complications. We think that the newly adopted sheet in our unit is likely to further enhance teamwork; increase understanding of a patient's necessary daily goals and decrease ICU and hospital stay.

The US-based National Quality Forum, with support from the Agency for Healthcare Research and Quality (AHRQ), has identified 30 safe practices that can work to reduce or prevent adverse events and medical errors. Amongst these is the documentation of verbal orders in order to verify the accuracy of what was heard such as use of Daily Goal Sheet (AHRQ Publication 2005). In addition, Group Interaction in High Risk Environments (GIHRE) investigators recommended the use of Daily Goal Sheets as one of the ways to improve team performance (Sexton 2004). This shortterm goal sheet has broad applicability for in-patient medicine and is now used in many ICUs. More than 50 ICUs in a wide variety of hospitals have adopted it as part of their rounds since the system was first developed at Hopkins.

Conclusion

The day is fast approaching when quality improvement will be universally viewed as a core component of providing safe patient care. Due to the complexity of information being shared in the ICU, a tool is needed to focus all recommendations coming from various sources, thus producing a reliable action plan. Creating tools like daily goal sheets, discussing patient's care in a multi-professional team setting, and outlining objectives of the day will generate an efficient and streamlined approach to your work. It will create a consistent flow of communication and thus provide high quality care with attention to details and patient safety.

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