Standardized Nursing Handoff

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Introduction/Problem

The intensive care units at Beth Israel Deaconess Medical Center (BIDMC) have no standard handoff process which creates the opportunity for omissions or miscommunication in the exchange of patient information which poses potential harm to patients. This project aimed to explore the hypothesis that if a checklist is utilized during report listing standard components that need to be addressed during a handoff, nurses would be less likely to miss important information specific and relevant to the patient being discussed, while maintaining autonomy in their style of communication

The handoff communication between intensive care unit (ICU) nurses from shift to shift at BIDMC, which currently has no standard process, does not include all necessary information for effective continuity of care, creating the opportunity for omissions or miscommunication in the exchange of information which may pose potential harm to patients.

Aim/Goal

The purpose of this practice inquiry was to evaluate the information exchanged at the change of shift nurse to nurse handoff in an intensive care unit (ICU) at the BIDMC and to positively impact the culture of handoff communication by raising awareness of the potential harm associated with incomplete or miscommunication of patient information.

The Team

- Veronica Kelly MSN, RN
- Robert Lombardo MSN, RN, CCRN
- The nursing staff of Finard 4 MICU/SICU

The Interventions

- A questionnaire was developed to assess staff perceptions of handoff communication and 46 nurses were invited to participate. A ten-point checklist was created as a guide for handoff communication and it was trialed for four weeks. At the end of the trial period staff were again invited to share their perceptions in a repeat questionnaire

Results/Progress to Date

With a 50% response rate on both surveys respondents noted handoff was well organized using the tool. Improved knowledge of reason for ICU admission, plan of care for the on-coming shift and pertinent social issues were noted. Use of the tool raised awareness of the potential risk of harm to the patient caused by omitted information.

For more information, contact:

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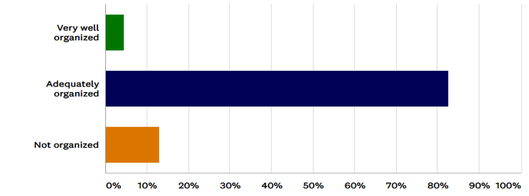
More Results/Progress to Date

Q3

How well organized is the report/handoff you receive?

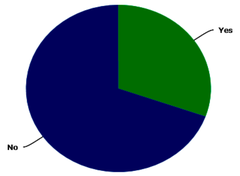
Answered: 23 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very well organized	4.35%	1
Adequately organized	82.61%	19
Not organized	13.04%	3
TOTAL		23

Are you aware that the World Health Organization, the Joint Commission and the Agency for Healthcare Research and Quality (AHRQ) have identified handoff between healthcare professionals as the root cause for serious medical errors in more than 70% of the time?

Answered: 23 Skipped: 0



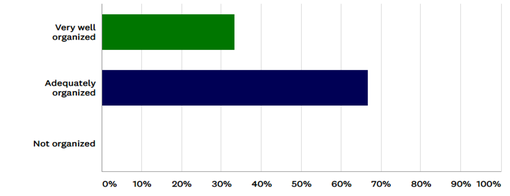
ANSWER CHOICES		RESPONSES	
Yes		30.43%	7
No		69.57%	16
Other (please specify)	Responses	0.00%	0
TOTAL			23

Significant Pre-intervention Survey results

Q3

How well organized is the report/handoff you receive?

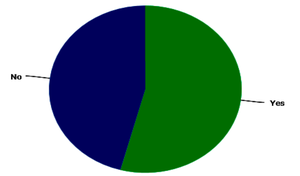
Answered: 24 Skipped: 0



ANSWER CHOICES	RESPONSES	
Very well organized	33.33%	8
Adequately organized	66.67%	16
Not organized	0.00%	0
TOTAL		24

Are you aware that the World Health Organization, the Joint Commission and the Agency for Healthcare Research and Quality (AHRQ) have identified handoff between healthcare professionals as the root cause for serious medical errors in more than 70% of the time?

Answered: 24 Skipped: 0



ANSWER CHOICES		RESPONSES	
Yes		54.17%	13
No		45.83%	11
Other (please specify)	Responses	0.00%	0
TOTAL			24

Significant Improvement in Handoff satisfaction Post-intervention

Lessons Learned

- According to the Joint Commission (2010), an estimated 80% of serious medical errors can be attributed to miscommunication by caregivers during patient handoff, and this has become a critical patient safety problem. It was not clear that staff recognized that a problem exists with handoff communication; this project sought to educate and inform nurses of the potential risks involved in handoff and positively influence the culture around handoff communication.

Next Steps

- This process improvement project has emphasized the potential harm caused by incomplete patient handoff communication. This is the first step in improving handoff communication; a positive impact on the culture. The checklist used should be formalized with staff input and adopted as the standard handoff format. Opportunity to spread the tool to the other intensive care units should be explored and a guideline should be developed for its use.

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