IMPROVED HANDOFF COMMUNICATION IN ADVANCED ENDOSCOPY

The Problem:

- Stoneman 4 GIadvance endoscopy nurses and anesthesia nurse practitioners found that patients coming for procedures from outside institutions aka round-trip patients, at times had incomplete medical records
- Patients undergo interventional GI procedures under sedation and need extensive pre-screening for co-morbidities.
- The GI team found that receiving a verbal report over the phone did not always provide adequate details (i.e., cardiac status, respiratory issues, etc.) which could potentially lead to delays in performing patient procedures.
- Health care organizations are required to “implement a standardized approach to handoff communications including an opportunity to ask and respond to questions”
  (Joint Commission NPSG, January 2006)
- Goals of nursing report are to provide continuity of care, assure patient safety, support efficiency of practice and adherence to professional standards and highlight acute changes in patient condition.
  (BIDMC Manual of Nursing Practice Guideline #100-3)

The Goal:

Our goal is to implement a standardized tool to gather complete and pertinent information on round-trip patients. This also ensures that patient safety goals are met.

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The Interventions:

- An intake form was formulated by GI nurses and the GI anesthesia team which was implemented July 2017.
- This form was used by the nurses when calling for report or handoff from outside hospitals.
- An online survey was conducted in March 2018 to evaluate effectiveness of the form.

Results/Progress to Date:

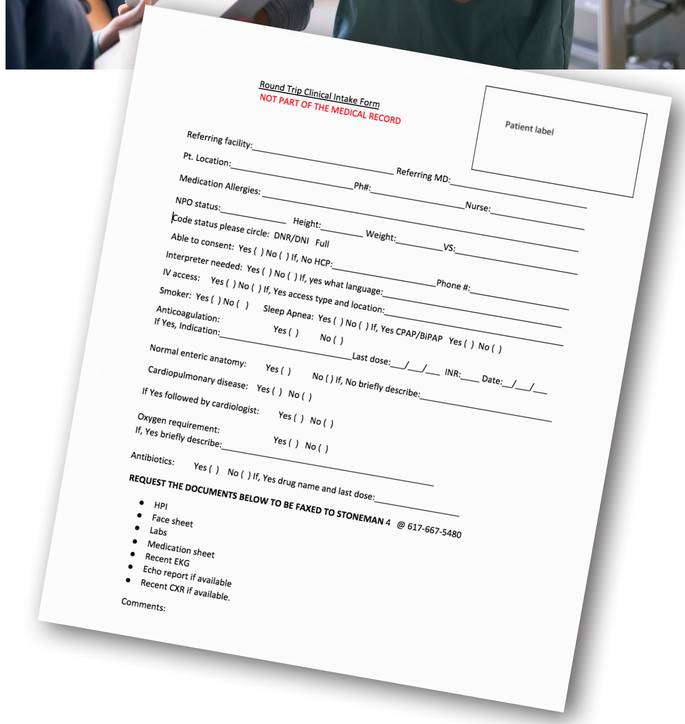
- Based on the survey results, 66.66% of the respondents use the current intake form.
- 100% of the respondents feel that the current form asks appropriate questions for gathering sufficient data.
- 100% of the respondents would like to continue using the current form.

Lessons Learned:

- Handoff communication styles differ between clinicians.
- The intake form helped standardize information exchanged between clinicians, and pertinent details were less likely to be missed.
- Improved communication resulted in a more comprehensive admission process.

Next Steps/What Should Happen Next:

- Present the intake form at the Ambulatory Leadership Committee as a tool other ambulatory procedural areas may want to trial.
- Continued re-evaluation of the form for the appropriateness and relevance of the questions included.
- Consider sharing the form with other departments who may take care of round-trip patients.



Round Trip Clinical Intake Form
NOT PART OF THE MEDICAL RECORD

Patient label

Referring facility:_____ Referring MD:_____
Pt. Location:_____ PH#:_____ Nurse:_____
Medication Allergies:_____
NPO status:_____ Height:_____ Weight:_____ VS:_____
Code status please circle: DNR/DNI Full
Able to consent: Yes ( ) No ( ) If, No HCP:_____ Phone #:_____
Interpreter needed: Yes ( ) No ( ) If, yes what language:_____
IV access: Yes ( ) No ( ) If, Yes access type and location:_____
Smoker: Yes ( ) No ( ) Sleep Apnea: Yes ( ) No ( ) If, Yes CPAP/BiPAP Yes ( ) No ( )
Anticoagulation: Yes ( ) No ( )
If Yes, indication:_____ Last dose:__/__/__ INR:____ Date:__/__/__
Normal enteric anatomy: Yes ( ) No ( ) If, No briefly describe:_____
Cardiopulmonary disease: Yes ( ) No ( )
If Yes followed by cardiologist: Yes ( ) No ( )
Oxygen requirement: Yes ( ) No ( )
If, Yes briefly describe:_____
Antibiotics: Yes ( ) No ( ) If, Yes drug name and last dose:_____

REQUEST THE DOCUMENTS BELOW TO BE FAXED TO STONEMAN 4 @ 617-667-5480

- HPI
- Face sheet
- Labs
- Medication sheet
- Recent EKG
- Echo report if available
- Recent CXR if available.

Comments: