



Patient Hand-off: Will an Organizational Standardized Handoff Tool that Mirrors Computerized Documentation Lead to Better Communication?



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Background

- Errors in handoff communication within healthcare has resulted in patient care errors, harm, deaths and high cost due to malpractice claims.
- Hand off processes that include mnemonics (e.g., SBAR, SIGNOUT) are used to improve handoff communication, but conclusive effect on communication is not clear.
- Studies have indicated that communication during interdepartmental handover is critical to ensuring patient safety. According to TJC, report standardization is critical, and this should be integrated into the electronic health record.
- Composite survey results for the 2019 Culture of Survey at Northern Light Eastern Maine Medical Center demonstrated need for improvement in hospital handoffs and transitions.
- This information was shared with the hospital-wide nursing Shared Governance Council and a sub-group was formed to work on patient handoff.

Practice Change

Increase interdepartmental communication regarding patient care using a standardized patient hand-off tool

Methods

- Collaboration across multiple departments, **EMMC Nursing Shared Governance** and nursing leadership to standardize information regarding patient care to be shared between nurses during handoff between departments and procedural areas.
- Standardized Patient Care Report tool was developed to be utilized and faxed when patients are transferring between departments or transporting to a procedure.
- Pre-survey conducted July 2020.
- Handoff rolled out.
- Post-survey conducted and findings reviewed 10/7/20.

Patient Hand-off Tool

PATIENT CARE REPORT

Primary RN: _____ Contact Number: _____

Admitting Physician: _____

Vital Signs: Time: _____ Temp: _____ BP: _____ HR: _____ RR: _____ SPO2: _____ Pain Score: _____

CODE STROKE: Yes No

CODE SEPSIS: Yes No

RELEVANT TX MEDICATIONS: _____

TESTS/PROCEDURES RESULT/SPENDING: _____

SOCIAL CONCERNS: Family with Other _____

PLACE OF ORIGIN: HOME SNF GROUP HOME TRANSFER

Neuro: _____

Cardiac: _____

Respiratory: _____

GIGU: _____

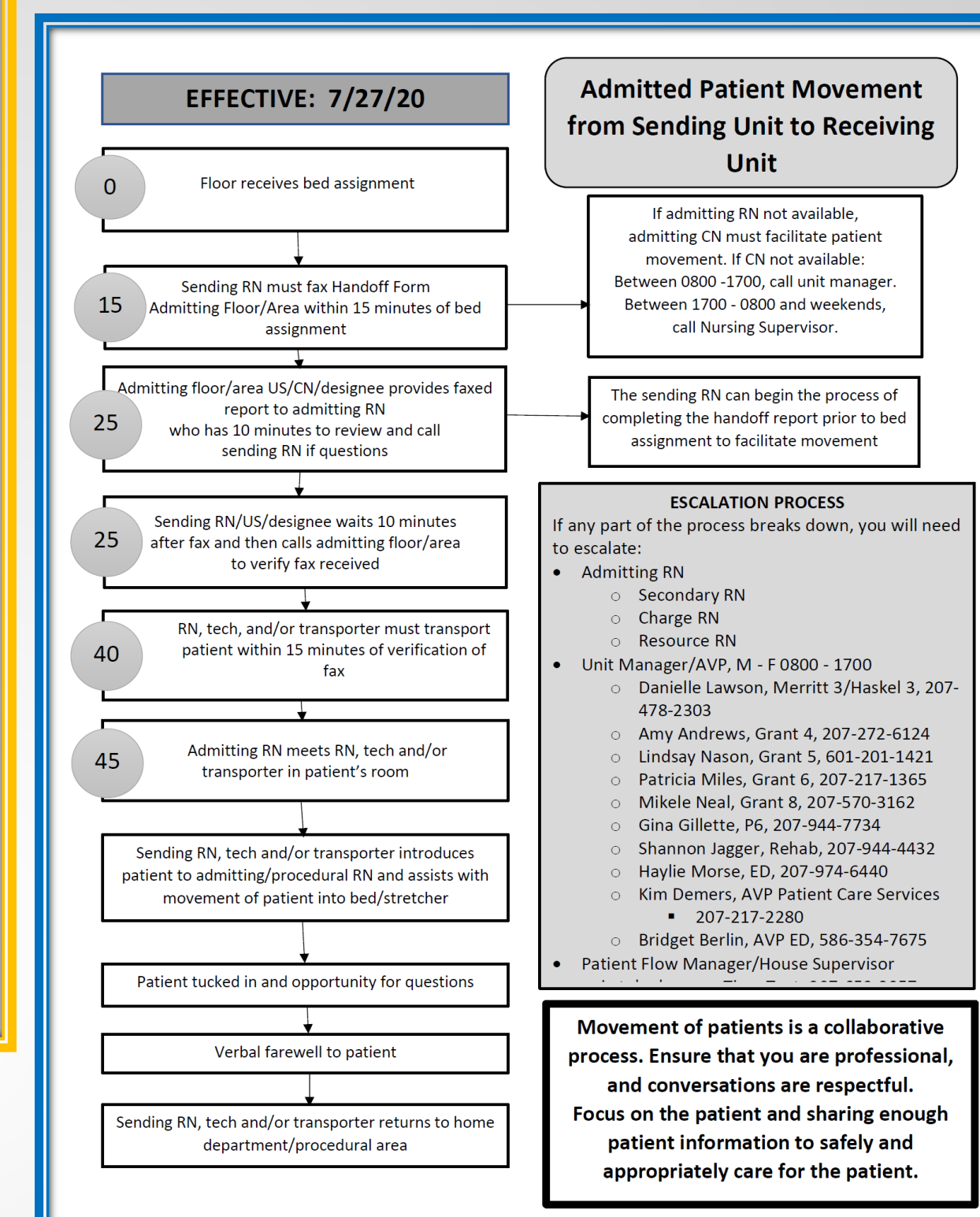
Diabetes: Yes No

Accucheck: _____ Time Last meal: _____ Last stool: unk

Behavioral Health: _____

EMAT score: _____

ABG: pH _____ pO2 _____ pCO2 _____



Post-Survey Findings/Discussion

Post-survey findings demonstrated a continued level of overall dissatisfaction with hand-off between departments.

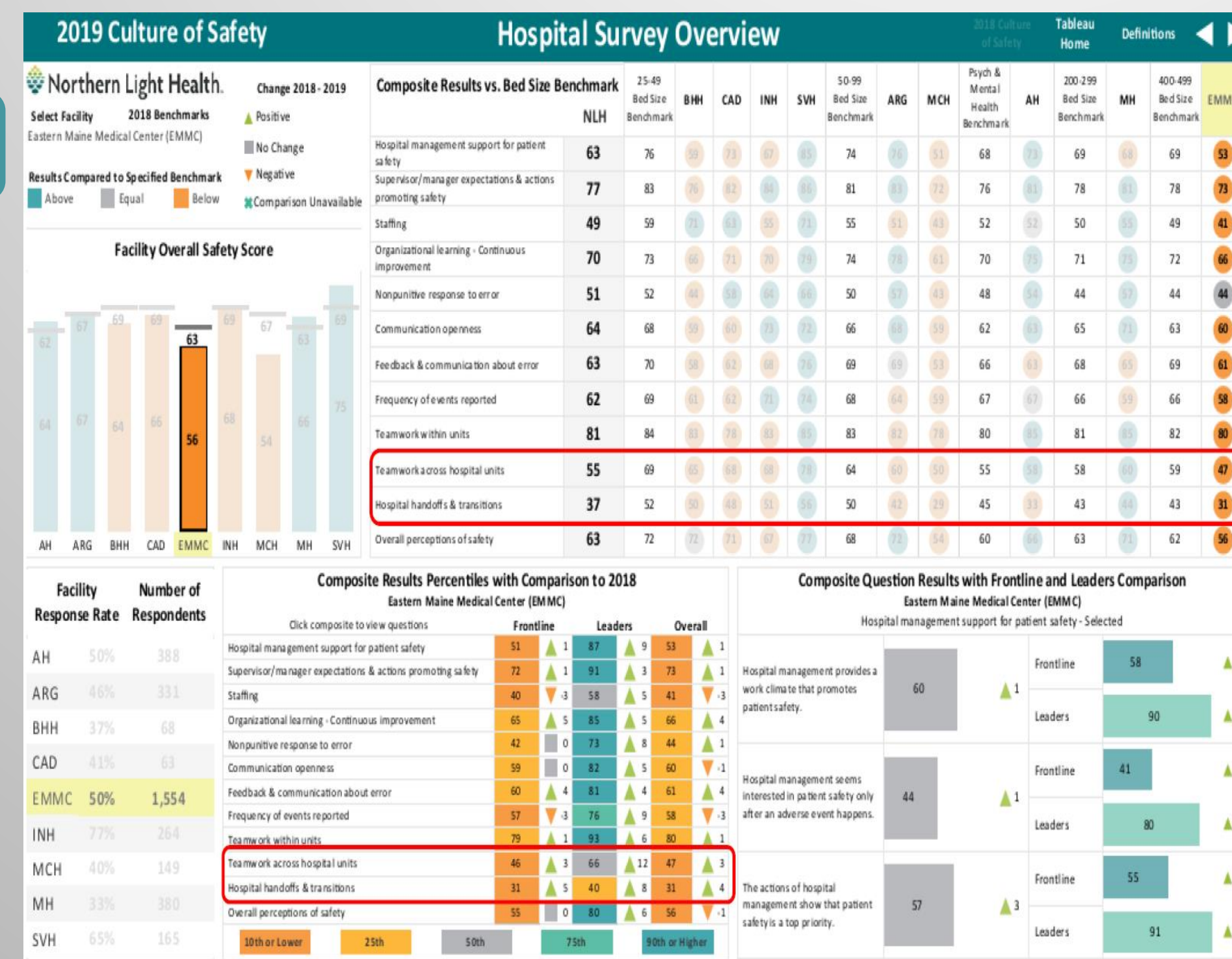
- “This current process takes longer & more time consuming to fill out.”
- “The paper process is a lot info/research on our end that receiving RN can see in the chart. Also, most of us can't even use the fax machine. A quick phone report has always worked well unless it is change of shift.”
- “Calling report tends to be more effective and safer for patient care.”
- “The sheet does not let you "tell the story".”
- “Most info can be found in chart.”

Conclusion/Next Steps

- Fax 30 was adopted to facilitate timely patient admits from the emergency room several months ago. Based on pre-survey results it was recognized that a standardized approach was needed to communicate patient information between departments. Multiple team members across several departments came together to modify the Fax 30 and adopt it for hospital-wide use.
- It is clear from the post-survey findings that bedside nurses do not feel that this tool leads to better communication.
- A review of these findings was shared with members of the Nursing Shared Governance Handoff Subcommittee and nurse leaders.
- Next steps include evaluation of the use of the electronic medical record for handoff considering the value nurses hold for verbal or face-to-face communication regarding patient care.

Pre-Survey Findings

2019 Culture of Safety Findings



Staff Survey Results

- Pre-implementation: Approximately 25-30% of staff surveyed found “Fax 30” handoff used timely and efficient.
- “Not enough information”
 - Current process does not always capture an accurate picture on what is going on with patients”
 - “No room to ask questions”.
 - “Timely but gives scanty information”
 - “Everyone does handoff differently so having a standard will be helpful”

References

Mohorek, M. & Webb, T.B. (2015). Establishing a conceptual framework for handoffs using communication theory. Journal of Surgical Education, 72(3), 402-409.

The Joint Commission. (2017). Sentinel alert event: Inadequate hand-off communication. Retrieved July 10, 2020 from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_1.pdf?db=web&hash=5642D63C1A5017BD214701514DA00139