Improvement of Inter-Unit Nursing Handoffs within the Department of Surgery at the Johns Hopkins Hospital

Background

The Institute of Medicine reports that communication failure accounts for the majority of sentinel events (Halm, 2013). Patients are harmed, and these failures in communication during the handoff can lead to adverse events that are entirely preventable (Beach, et al 2012). As one would expect, communication becomes particularly vulnerable during care transitions when a patient is transferred from one unit to another (Manser and Foster, 2011). With this in mind, the Joint Commission as well as the Institute of Medicine have established a requirement for standardization of this error-prone process since it is such a high risk event (Goldsmith, 2010) (Blaz, 2012) (Manser and Foster, 2011) (Halm, 2013). The literature highlights the many barriers to standardization for inter-unit handoff. It is important to recognize that the needs of the units involved are "context-dependent." As a result, when different specialties and services are collaborating for the continuous care of one patient, “handoff essentials” may be perceived very differently by the different care providers coordinating the handoffs (Blaz and colleagues, 2012).

With the literature in mind, a team of surgical nurses committed to evidenced-based practice concluded the following:

-Within the department of surgery, a consistent approach to nursing handoffs needs to be developed which will result in a standardized, yet unit-specific process in which information about patient care is consistently and reliably communicated.

-The team determined to find out if this was a widely recognized problem and whether nurses would be open to standardization.

Methods

A literature review was conducted which consisted of many recommendations, but little evidence-based practice. As a result, an online survey was developed using Survey Monkey and distributed to the nursing units within the department of surgery to gather more information on current practices. There were 13 closed ended selection questions and there was one open ended suggestions section where qualitative data was collected from the nurses regarding the quality of nursing handoffs between units. 152 nurses responded to the survey and 139 nurses completed it from the following units:

Survey Results

-Handoffs take majority of inpatient unit and ICU nurses 5-15 minutes; the majority of PACU reports take 0-5 minutes.
-87% of handoffs take place over the phone.
-60% of the nurses reported the use of a unit-created protocol/tool.

Survey Results continued

**Liker Scale style responses (teamwork and organization)**

- There is teamwork between my unit and other units.
- All of the necessary information to care for my patient is provided to me in an organized manner.
- I have been involved in a patient safety event related to a nursing hand-off miscommunication or lack of communication following the transfer of a patient from another nursing unit or specialty area.
- It is important to me to use a standardized format for hand-offs when transferring a patient to another nursing unit.

**Barriers identified**

- Timing of report
- Little knowledge of patient
- Lack of communication following hand-off miscommunication or omission
- Information may be less related to communication and inaccuracy. When to nursing handoffs, but it can address issues related to communication and inaccuracy. When
- There is teamwork between my
- One patient, “handoff essentials” may be perceived very differently by the different care providers coordinating the handoffs (Blaz and colleagues, 2012).

Tool Development

A new tool was developed based on the following resources (1) the literature, (2) tools currently used by participating units, and (3) focus group discussion with nurses from participating units:

**Focus Group Goals for a Department-wide Tool:**

1. Logical, Systematic, and Universal (usability for all units)
2. “Open Concept” (Format/Organization up to the user)
3. Use of “trigger words” (nothing falls through the cracks)
4. Logical, Systematic, and Universal (usability for all units)
5. From a handwriting format to a standardized tool.

Who are they? (case history, contact information, RN/PSA, safety concerns)

Recent Course who happened over the last four days

Current Status (Assessment, relevant diagnostics, and medications w/last dose)

Future Course and Red Flags

References


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