

Nurse to Nurse Handoffs in the Cardiovascular Surgical ICU

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1 Background

In order to provide consistent care to patients, nurses must exchange pertinent patient information in an efficient yet detailed manner. This “handoff” is especially imperative as the information gathered from the outgoing nurse will guide the plan of care for the nurse beginning his or her shift. A poor handoff can result in inadequate care, ineffectual outcomes, and even adverse events (Friesen, 2008).

Many tools have been developed in order to ensure the efficacy of the nurse to nurse handoff. In 2006, the Joint Commission with input from the Sentinel Event Advisory Group made it a prioritized requirement that all acute care facilities implement a standardized approach to handoff communication (Friesen, 2008). Despite handoffs being made a priority by the Joint Commission, very little research has been done on the efficacy of the various handoff tools used in the hospital setting (Abraham, 2013).

The Cardiovascular Surgical ICU at Johns Hopkins Hospital looked to improve the handoff model on their nursing unit. To gain a clear understanding of the transfer of quality patient information, the unit’s Quality Improvement team created a handoff audit form that could track information that may be left out of the handoffs.

2 Objectives

In order to drive the project, the QI team developed these objectives:

- 1) Develop a handoff tool that improves efficacy of the information communicated.
- 2) Identify valuable information missed during handoffs.

3 Methods

A handoff audit form (see Figure 1) was given to every nurse upon the start of every shift. After the oncoming nurse received their patient handoff from the outgoing nurse, he or she would complete the audit checklist – marking if the outgoing nurse had addressed all aspects of the handoff. The audit forms were collected, counted, and the data was entered into simple excel spreadsheets where compliance could be tracked from one to another. Data was collected for six months.

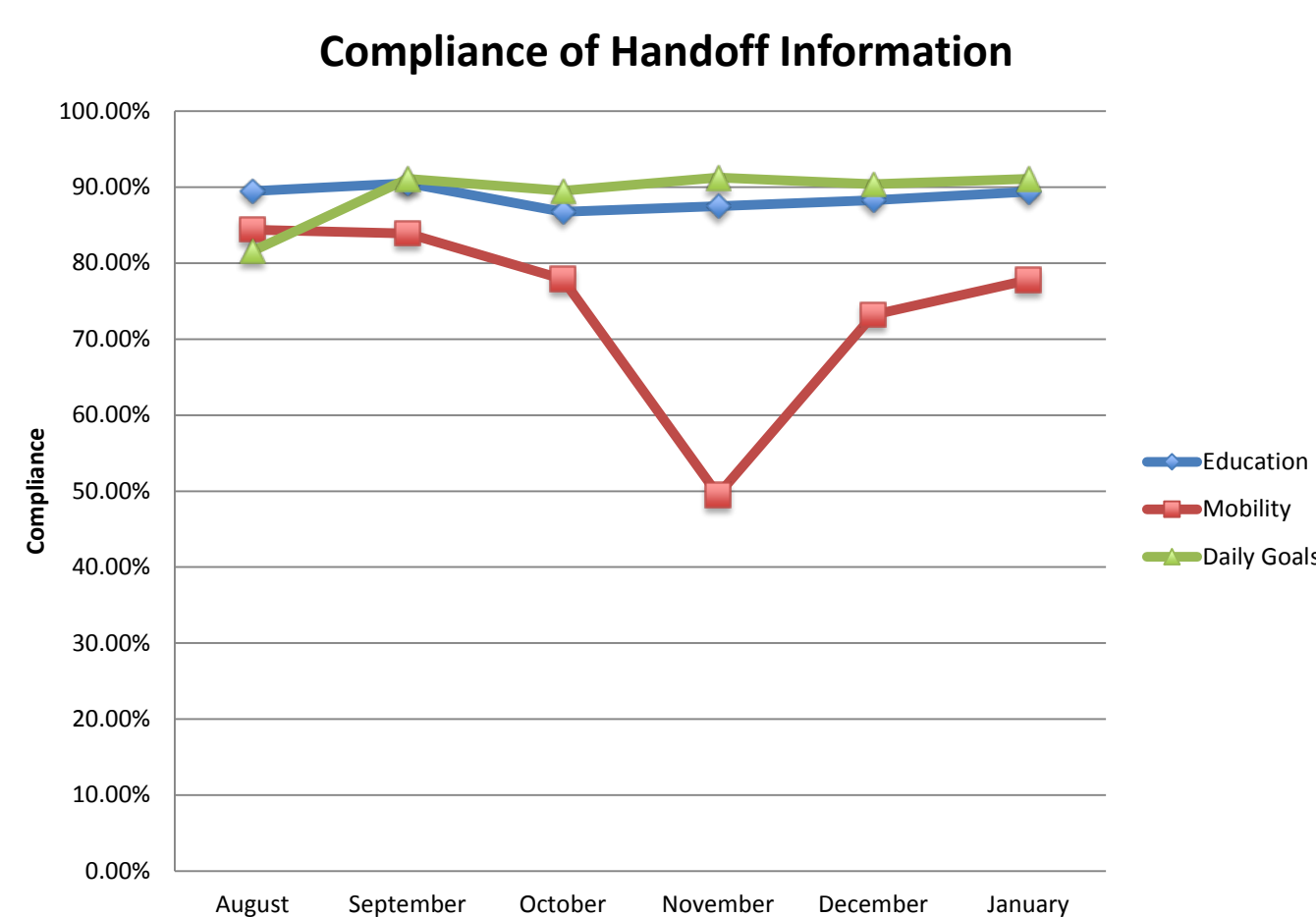


Figure 1

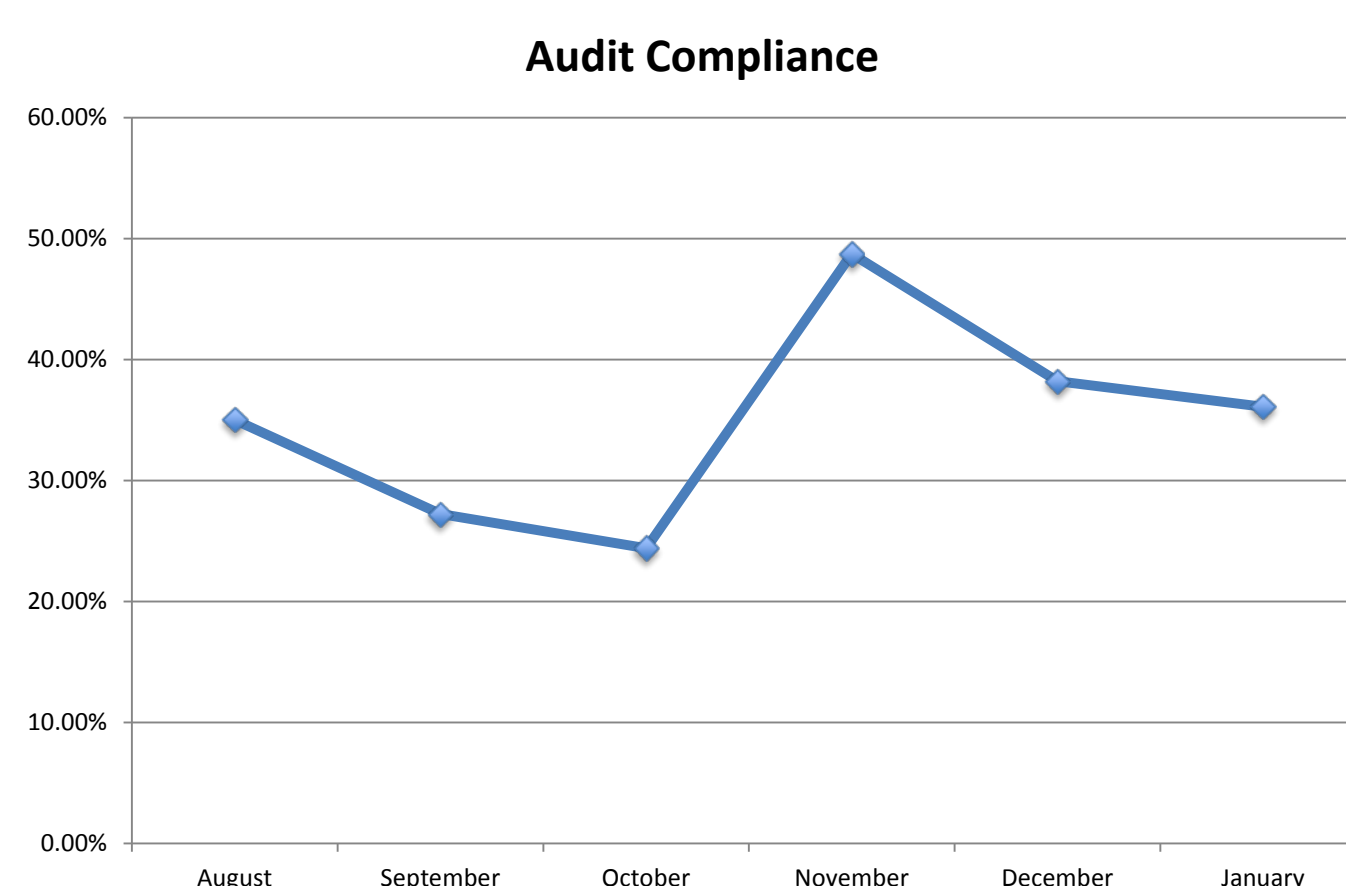


Figure 2

4 Results

Three elements of the handoff were looked at: Patient Mobility Status, Education, and Patient Daily Goals. Throughout the six months, both Education and Daily Goals remained relatively constant with nurses reporting that during the handoff, Education and Daily goals were included in the handoff 86.67-90.5% and 81.6-91.25% of the time respectively (see Figure 1). However, patients’ mobility status had a much broader range: 49.5-84.4% (see Figure 1).

The data collected shows inconsistency in nurse compliance with the three data metrics. The overall compliances ranged from 24.4-48.72% (see Figure 2). An intervention implemented to increase compliance with use of the handoff tool included 1:1 reminders to bedside nurses on the importance of consistent use of the handoff tool. Feedback from the nurses during these sessions identified reasons compliance may not be consistent (i.e. the project was not a priority, the project lacked value, etc.).

Due to the lack of participation, it was difficult to tease out whether nurses were inconsistently giving information on patient mobility or if the data was just skewed based on a small data set.

5 Conclusions

The data that was collected showed that information on education and daily goals was delivered relatively consistently, and information on mobility was less consistent. The results of this study were difficult to translate into a future direction due to a lack of participation from the nurses on the unit. Because of this, the study was ended earlier than expected.

6 Future Directions

Looking forward in this area of nursing research, it would be necessary to gain support and input from the staff and realize a project that would be supported. Also, a study would need to be conducted to see if a handoff checklist or other tools could decrease adverse events and improve patient care.

7 References

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