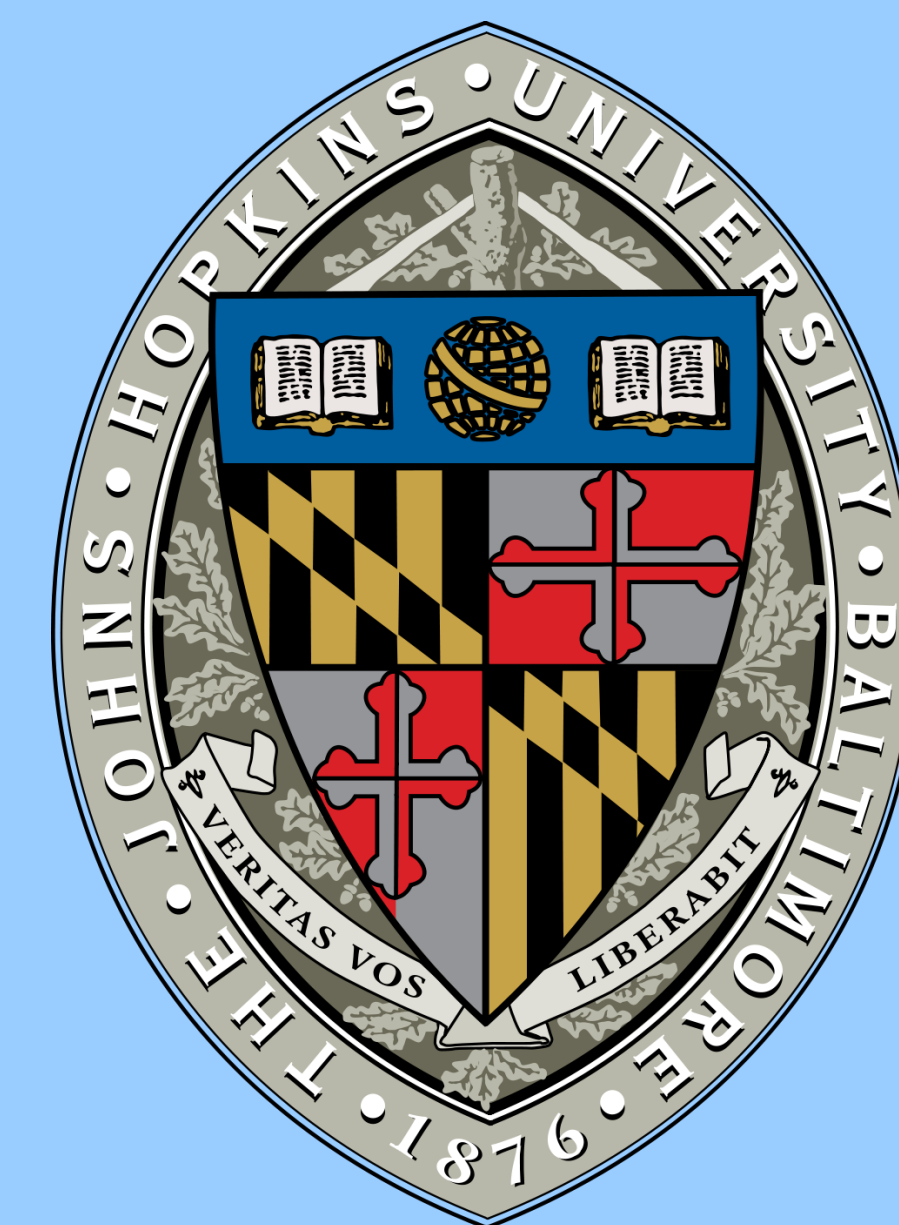


Nursing Handoff Process in the Children's Center

Rhonda DS Wright, MHSA
Johns Hopkins University School of Nursing, Baltimore, MD

Sherri E. Jones, MSN, RN
Assistant Director of Nursing Pediatrics
Johns Hopkins Children's Center
Baltimore, MD



1 Background

An intradepartmental transfer from one level of care or unit to another can be a very vulnerable and dangerous time for a patient with potential for error and communication breakdown. Often, patients are transferred throughout the Children's Center with missing key components to their history, plan of care, and other vital pieces of information that can ultimately compromise patient safety.

Objectives

- To make patient transfers more safe:
- To update the standardized handoff tool
- To identify other relevant factors that affect handoff.
- To improve the overall handoff process.

2 Methods

To update the standardized handoff tool, a five-question Likert scale satisfaction survey was developed On Qualtrics. The survey was distributed to 802 Children's Center nurses in 10 patient units with a return rate goal of approximately 18% (150 surveys). Results were intended to determine what changes if any should be made to the tool.

Finally, units expressing marked dissatisfaction were interviewed by the Assistant Director for Nursing for additional feedback.

3 Results

One hundred thirty-one nurses responded yielding a 16.3% response rate. Table 1 shows the distribution of returned surveys for each of the participating Children's Center units.

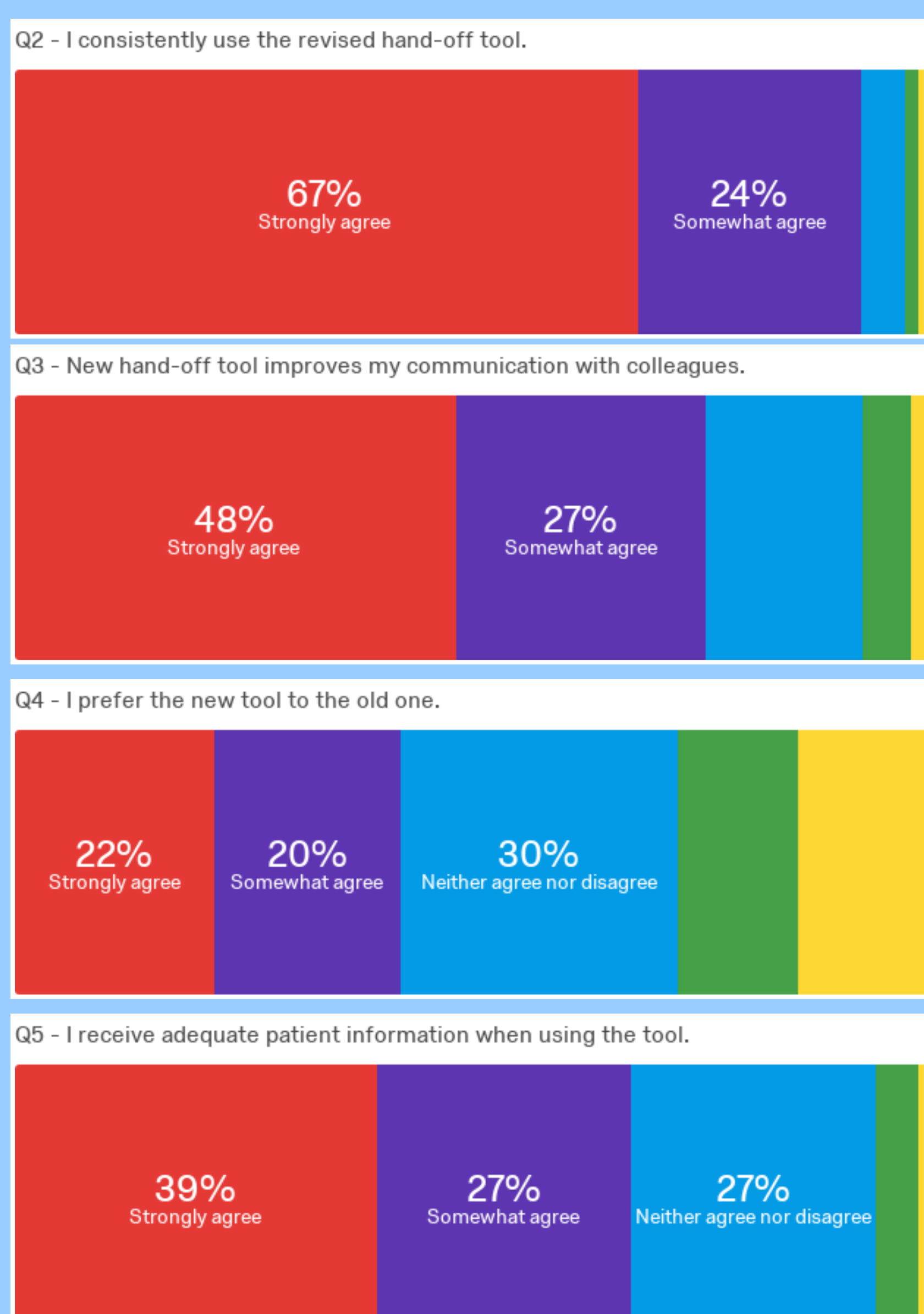
Table 1: Number of Completed Surveys

UNIT	# of Surveys
PED	30
PACU/PR EP	17
PICU	13
NICU	9
9S	17
9N	16
10S	14
10N	6
11S	5
12S	4
TOTAL	131

Results from the Pediatric Emergency Department (PED) revealed most significant dissatisfaction with the handoff tool. Thirty-eight percent strongly disagreed, 21% somewhat disagreed with preferring this handoff tool to previous versions.

Free-text feedback and focus group with the PED highlighted their specific concerns around primarily being a "sending" unit. Many nurses shared a culture and lack of understanding from "receiving" units.

Minor changes were made to the tool before being made available organization-wide via Forms On Demand.



4 Conclusions

1. Minor content and arrangement changes were made to the handoff tool.
2. Most receiving units were satisfied with the handoff tool.
3. Sending units naturally have different communication needs than receiving units and tool needs to reflect those.

The data collection process emphasized a need for cultural change beyond the revision of a tool. Processes surrounding the use of the tool require examination as well

5 Future Directions

Future direction of this project include:

1. Examining beyond the tool itself but rather how it best implemented
2. A closer look at communication factors affecting the handoff process

6 References

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