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

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1 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.

2 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:

<u>Inpatient Units</u>
Marburg 2
Marburg 3
Weinburg 4C
Weinburg 4D
Zayed 9W
Zayed 10W
Zayed 11E
Zayed 11W
Halsted 3/Osler 3

<u>Perioperative Units</u>
Weinburg PREP/PACU
Zayed 3 PREP/PACU
Zayed 5 PREP/PACU
JHOC PREP/PACU
OR

<u>Intensive Care Units</u>
SICU
WICU
CVSICU

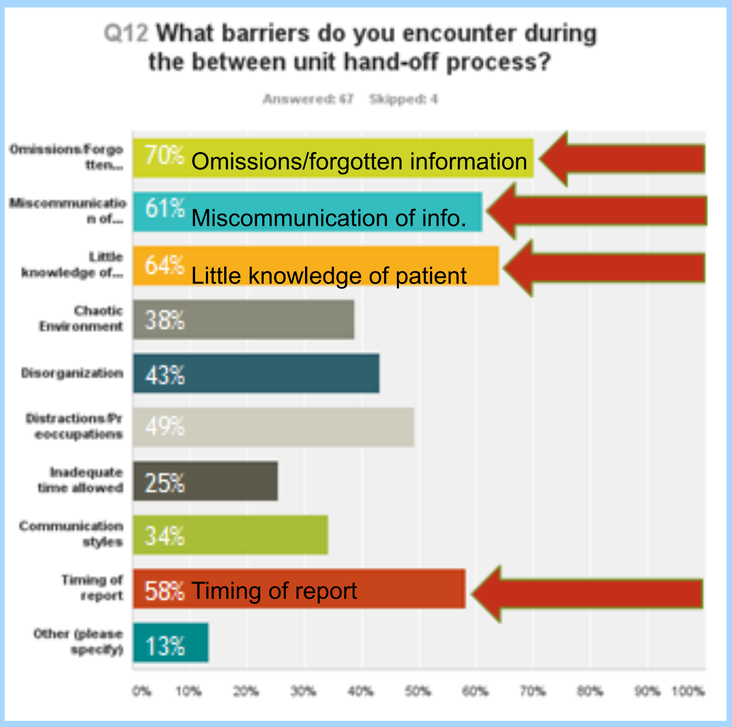
3 Survey Results

- 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

3 Survey Results continued

- **<u>Likert Scale style responses (teamwork and organization)</u>**
  - *There is teamwork between my unit and other units.* — 11% Disagree / 62% Agree
  - *All of the necessary information to care for my patient is provided to me in an organized manner.* — 12% Disagree / 63% Agree
  - *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/ specialty area.* — 43% Disagree / 46% Agree
  - *It is important to me to use a standardized format for hand-offs when transferring a patient to another nursing unit.* — 12% Disagree / 81% Agree

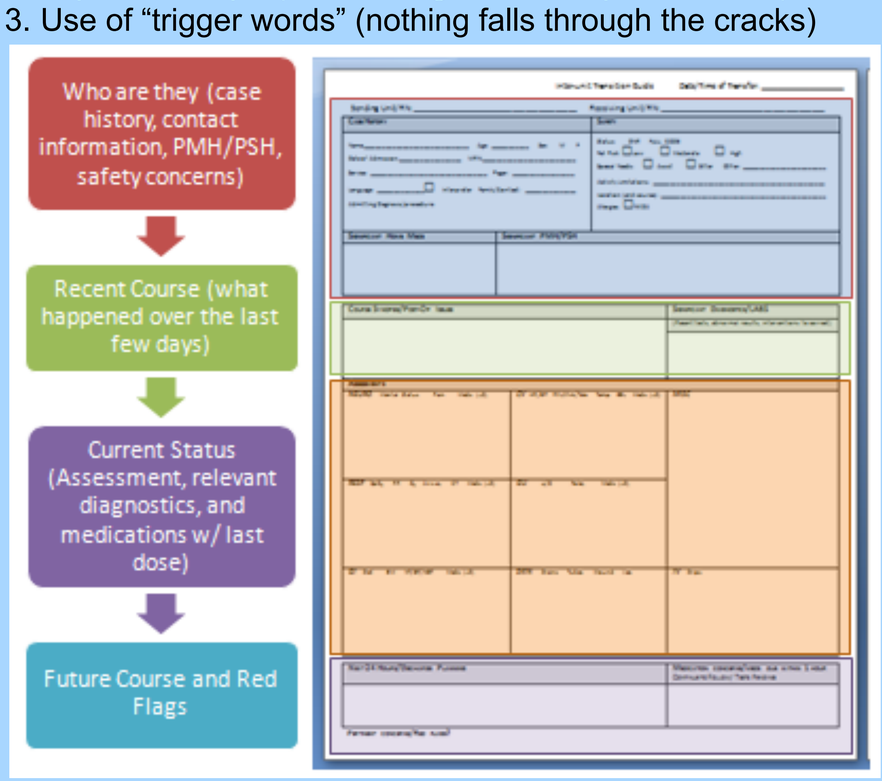
- **<u>Barriers Identified</u>**



4 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.

<u>Focus Group Goals for a Department-wide Tool:</u>
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)



5 Conclusions

1. Nursing handoffs involving miscommunication contribute to patient safety events within the department of surgery.
2. According to nurses in the department of surgery, omissions and forgotten information are the largest contributors to communication failure.
3. Omissions and Forgotten information can be easily addressed through the use of a standardized tool.
4. Many nurses within the department of surgery would be open to the standardization of the inter-unit handoff process.
5. New nurses in particular would benefit from an organized, open handoff tool.

Standardization cannot address *all* of the barriers to nursing handoffs, but it can address issues related to communication and inaccuracy. When each nurse looks at the same tool and speaks the same language– information may be less likely to fall through the cracks, and the process can become more organized and efficient.

6 Future Directions

The team has spoken with nursing staff to receive preliminary feedback on the design and elements contained within the tool. In the coming months, the tool will be tested, revised, and ultimately piloted within the department of surgery. Additionally, the team has been collaborating with a team from Bloomberg to further revise and evaluate the nursing handoff in an effort to produce a tool that may be incorporated into EPIC in the future.

7 References

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