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

Patient Label		Safety	☐ Forensics/Custody ☐ High Risk ☐ Accommodations ____
		Code Status	☐ Full Code ☐ DNR Unless otherwise noted patient is full code
Primary RN	Contact Number	Allergies	☐ NKDA ☐ Contrast Dye ☐ See EMR
Admitting Physician		Precautions	☐ Fall ☐ Seizure ☐ Other _____
Admitting Diagnosis		Isolation Required	☐ No ☐ Yes Type: _____

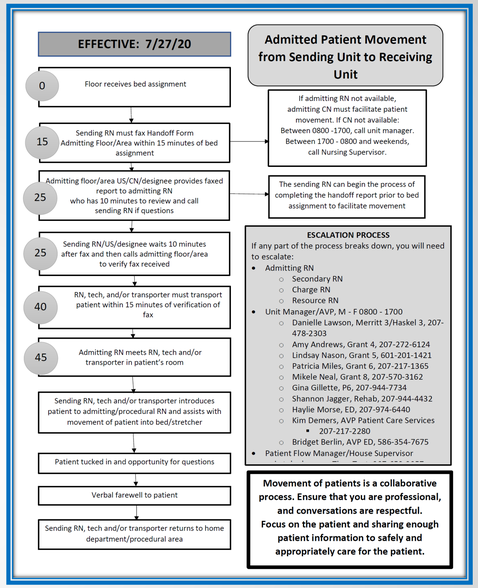
Vital Signs	Time	Temp	BP	HR	RR	SPO2	Pain Score / Location

CODE STROKE	CODE SEPSIS	RELEVANT TX MEDICATIONS	TESTS/PROCEDURES RESULTS/PENDING	SOCIAL CONCERNS
☐ Yes ☐ No NIHSS Stroke Scale _____ Deficits: _____ Neuro Checks: _____ Dysphagia Screen: ☐ Pass ☐ Fail	☐ Yes ☐ No IV DRIPS/FLUIDS #1 #2 ACCESS TYPE: _____			☐ Family with pt ☐ Other _____ PLACE OF ORIGIN ☐ HOME ☐ SNF ☐ GROUP HOME ☐ TRANSFER

Neuro:	Cardiac:	Respiratory:	GI/GU:
GCS _____	Telemetry/Continuous Pulse Ox Order ☐ Yes ☐ No	O2 Therapy ☐ Yes ☐ No	☐ Peg ☐ G-tube ☐ Foley ☐ Incontinent Urine Output _____
Hx of Seizure ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No AICD ☐ Yes ☐ No Form Complete ☐ Yes ☐ No	☐ NC ____ ☐ Mask ____ ☐ BiPaP ☐ Trach ☐ Extubation date: _____	Dialysis ☐ Yes-Last Dialysis ____ ☐ No Graft ☐ Yes-Graft Site _____ ☐ No
Orientation ☐ Person ☐ Place ☐ Time	12 Lead EKG on chart ☐ Yes ☐ No	☐ Nebulizer, Last treatment time _____	Diabetes ☐ Yes ☐ No Accucheck _____ Time _____ Last meal _____ Last stool ____ ☐ unk

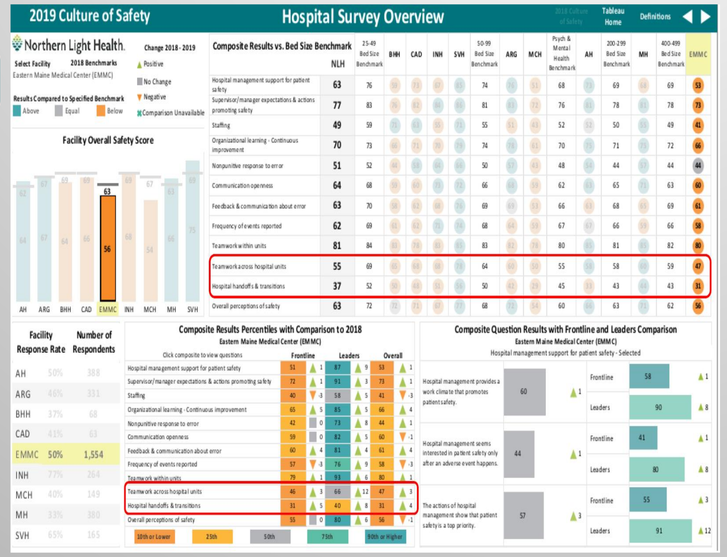
Skin: Braden Score: ____	Behavioral Health:	Labs: all WNL unless otherwise reported below	
Skin issues ☐ Yes ☐ No Or pressure injury _____	Suicidal Risk ☐ Yes ☐ No Assault Risk ☐ Yes ☐ No Elopement Risk ☐ Yes ☐ No	☐ CK ____ TROP 1 ____ Next Level Due ____	☐ ETOH ____ Date last drink____ Time last drink____
Fall: Morse score: ____	Mobility: BMAT score: ____	☐ H/H ____ ☐ PT ____ ☐ PTT ____ ☐ Gluc ____ ☐ INR ____ ☐ K+ ____ ☐ W ____ ☐ BUN ____ ☐ Crea ____ ☐ Mg ____ ☐ Phos ____ ☐ Na+ ____	Positive Drug Screen ☐ Methadone ☐ Barbiturate ☐ Opiate ☐ Phenytoin ☐ Amphetamine ☐ Benzo ☐ Marijuana ☐ Phencyclidin ☐ _____
Recent Fall ☐ Yes ☐ No When _____	Ambulatory ☐ Yes ☐ No ☐ Walker ☐ Cane ☐ Bed Bound	ABG: pH ____ pO2 ____ pCO2 ____	Pregnant ☐ Yes ☐ No ☐ N/A Urine HCG Completed ☐ Yes ☐ No Quant. Result

Please call the Sending Unit/RN if you have questions regarding your patient. Time Completed: _____ Time Faxed: _____



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"

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.

References

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