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.
- Handoff 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

![Image of Patient Hand-off Tool]

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


2019 Culture of Safety Findings

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”

Staff Survey Results

- “This current process takes longer & more time consuming to fill out.”
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