Patient Hand-off Between Then ED and ICU: Perceptions of Current Practices That Lead to a Hand-off Tool

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Background

- Of 2,000 sentinel events analyzed by The Joint Commission, communication breakdowns were determined to be the primary root cause of 60%.
- Errors, care omissions, treatment delays, inefficiencies, inappropriate treatment, adverse events, increased length of stay, avoidable readmissions, and increased costs have all been attributed to substandard or variable handoffs.
- Patient handoffs that have been found to be highly reliable and successful incorporate 3 elements: face-to-face, 2-way communication; structured written forms, templates, or checklists; and content that "captures intention," shared between healthcare providers.

Practice Change

- Reduce substandard hand-off consequences that can lead to poor patient experiences/outcomes by creating a standardized hand-off tool based upon perceptions of current practices between the ED and ICU at Eastern Maine Medical Center.

Methods

- Develop survey to gather nurse/perception/satisfaction of current bedside handoff between ED and ICU.
- Gain project approval from ED and ICU management.
- Distribute/email educational email and survey to all nursing staff of ED and ICU. Reminders given at huddles and weekly updates.
- Collect surveys, evaluate findings, and develop handoff tool.

Measures and Results

Patient Hand-off Questionnaire

In your experience with patient handoff between the ED and ICU, how would you describe you experience as a whole?

Would you say you've had more good experiences, bad experiences, or about the same? And why.

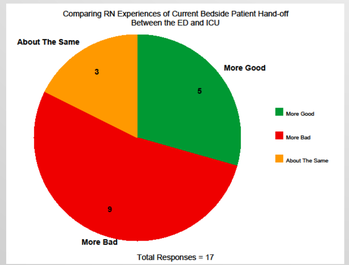
What has gone well in the past?

What are some examples of things that could have gone better?

Have you had anything serious happen that could have caused harm to the patient during a handoff?

What other comments/recommendations do you have that could better improve future handoffs between the ED and ICU? Be specific.

Results



"What has gone well in the past?"

- "phone report from the actual RN who has cared for the patient" (5/17)
- "experienced nurses that know the patient before attempting report"
- "the nurse caring for the patient gave report during handoff"
- "more of a heads up"
- "an actual time out with a comprehensive report"
- "a call before transport"
- "transfer happened for a time that worked well for both nurses"
- "many hands in room to help move patient to bed"
- "bedside report"
- "the patients are alive"
- "in general, interactions have been positive with ED nurses."

"How would you describe your experience?"

- "Report is often rushed and not complete"
- "There are too many distractions during bedside report while settling the patient"
- "Needs to be more organized"
- "Better patient satisfaction"
- "Generally has gone well"
- "Much better than experiencing handing off to the floors"
- "Sometimes the RN transporting the patient wasn't the primary RN so very little is known about the patient, sometimes missing important information"
- "Need more of a heads up before patient arrives to the ICU"
- "Not good"
- "Need to be better communication"
- "Not working well."

Summary/Discussion

Other comments/recommendations to better improve future handoffs between the ED and ICU:

- 7 out of 17 responses think that: "Phone report from the actual RN who cared for the patient would be beneficial prior to the patient being admitted to the ICU and then finish report at the bedside"
- "Call to arrange a time for the transfer"
- "Slow down the process"
- "Settle patient, place on monitor and then stop and give report without distractions"

Survey results show that RNs involved with current bedside handoff practices are overall not satisfied with how things are going. These findings indicate that a change needs to occur which would allow safe and optimal patient care during transfers between the ED and ICU.

By developing a handoff tool which could be utilized with each ED to ICU transfer, this would allow consistency and effectiveness for patient care so as to eliminate any unsafe situations which could lead to unwanted patient harm.

Limitations

Although the surveys were available to staff for two weeks, only 17 surveys were filled out and returned.

Conclusion

- The general consensus from the results show that changes need to be made in order for the ED to ICU handoff to improve
- Data shows that implementing a SBAR structured handoff tool would make a positive change by reducing communication errors or care omissions while continuing with current bedside report practice

References

Benjamin, M.F., Hargrave, S., & Nether, K. (2016). Using the Targeted Solutions Tool to Improve Emergency Department Handoffs in a Community Hospital. *The Joint Commission Journal on Quality and Patient Safety*, 42(3), 107-114. doi:10.1016/s1553-7250(16)42013-1

Halm, M.A. (2013). Nursing Handoffs: Ensuring Safe Passage for Patients. *American Journal of Critical Care*, 22(2), 158-162. doi:10.4037/ajcc2013454