Nursing Handoff Report Guideline

Alex Joseph Francisco

Touro University Nevada

In partial fulfillment of the requirements for the

Doctor of Nursing Practice

DNP Project Chair: Jessica Grimm

DNP Project Member(s): Denise Zabriskie and Karen Grimley

Date of Submission: January 29, 2019

Abstract

Communication between healthcare professionals is a critical period in the exchange of patient information to ensure patient safety and continuity of care. It has been reported that preventable medical errors have resulted in 98,000 patient deaths per year in the United States. The identified problem in the Preoperative Treatment Unit at an urban Los Angeles hospital is the lack of standardization during the handoff transition at break reliefs and at shift change. The purpose of this doctoral project is to apply evidence-based practices of handoff reports for standardization to improve staff satisfaction and perception of handoff quality. This doctoral project aimed to decrease sentinel event rates and to assess the nurses' perception and satisfaction of the handoff process before and after the implementation of the Nursing Handoff Report Guideline (NHRG). The implementation process began with a comprehensive literature review and collaboration with key stakeholders. The nursing staff was asked to complete the pre-survey of their current perception and satisfaction, followed by an educational in-service meeting. After the four-week period, the nursing staff completed the post-survey, with results inputted into SPSS for evaluation using the paired t-test. Results demonstrated there was a statistically significant increase in the nurses' satisfaction and perception of handoff reports utilizing the NHRG. Further observation is needed to evaluate the NHRG's effect on sentinel event rates. This doctoral project promotes the nursing profession by developing nursing communication, endorsing patient safety, and ensuring continuity of care.

Keywords: standardized handoff report, handoff satisfaction, handoff checklist

References

Agency for Healthcare Research and Quality. (2017, June). Handoffs and Signouts. Retrieved from https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts

Agency for Healthcare Research and Quality. (2018, March). About SOPS. Retrieved from https://www.ahrq.gov/sops/quality-patient-safety/patientsafetyculture/index.html

Agency for Healthcare Research and Quality. (2018, March). Hospital Survey on Patient Safety Culture. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalsopsreport.pdf

American Society of PeriAnesthesia Nurses. (2016). *2017-2018 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements*. Cherry Hill, NJ.

Arora, Auerbach, and Melin. (2017) Patient handoffs. Retrieved from https://www-uptodate-com.lb-proxy2.touro.edu/contents/patient-handoffs?search=patient%20handoffs&source=search_result&selectedTitle=1~4&usage_type=default&display_rank=1

Berger, J., Sten, M., & Stockwell, D. (2012). Patient handoffs: Delivering content efficiently and effectively is not enough. *International Journal of Risk and Safety in Medicine, 24*(4), 201-205.

Blegen, M. A., Gearhart, S., Obrien, R., Sehgal, N. L., & Alldredge, B. K. (2009). AHRQs Hospital Survey on Patient Safety Culture. *Journal of Patient Safety,5*(3), 139-144. doi:10.1097/pts.0b013e3181b53f6e

Boat, A. C., & Spaeth, J. P. (2013). Handoff checklists improve the reliability of patient handoffs in the operating room and postanesthesia care unit. *Pediatric Anesthesia,23*(7), 647-654. doi:10.1111/pan.12199

Bruno, G. M., & Guimond, M. E. (2017). Patient care handoff in the postanesthesia care unit: A quality improvement project. *Journal of PeriAnesthesia Nursing,32*(2), 125-133. doi:10.1016/j.jopan.2015.10.002

Chenault, K., Moga, M., Shin, M., Petersen, E., Backer, C., Oliveira, G. S., & Suresh, S. (2016). Sustainability of protocolized handover of pediatric cardiac surgery patients to the intensive care unit. *Pediatric Anesthesia,26*(5), 488-494. doi:10.1111/pan.12878

Cornell, P., Gervis, M., Yates, L., & Vardaman, J. (2013). Improving shift report focus and consistency with the Situation, Background, Assessment, Recommendation Protocol. *The Journal of Nursing Administration, 43*(7/8), 422-428.

Cummings, S., Bridgman, T., & Brown, K. G. (2016). Unfreezing change as three steps: Rethinking Kurt Lewin's legacy for change management. *Human Relations,69*(1), 33-60. doi:10.1177/0018726715577707

Foronda, C., VanGraafeiland, B., Quon, R., & Davidson, P. (2016). Handover and transport of critically ill children: An integrative review. *International Journal of Nursing Studies,62*, 207-225. doi:10.1016/j.ijnurstu.2016.07.020

Gagnier, J. J., Derosier, J. M., Maratt, J. D., Hake, M. E., & Bagian, J. P. (2016). Development, implementation and evaluation of a patient handoff tool to improve safety in orthopedic surgery. *International Journal for Quality in Health Care,28*(3), 363-370. doi:10.1093/intqhc/mzw031

Hall, H. R., & Roussel, L. A. (2016). *Evidence-based practice: An integrative approach to research, administration, and practice*. Burlington, MA: Jones & Bartlett Learning.

Halm, M. (2013). Nursing handoffs: Ensuring safe passage for patients. *American Journal of Critical Care, 22*(2), 158-162.

Horwitz, L., Moin, T., & Green, M. (2007). Development and implementation of an oral sign-out skills curriculum. *Journal of General Internal Medicine, 22*:1470-74.

Hussain, S. T., Lei, S., Akram, T., Haider, M. J., Hussain, S. H., & Ali, M. (2016). Kurt Lewin's change model: A critical review of the role of leadership and employee involvement in organizational change. *Journal of Innovation & Knowledge*. doi:10.1016/j.jik.2016.07.002

IOM. (1999). To err is human: Building a safer health system. *National Academy of Sciences*. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/1999/To-Err-isHuman/To%20Err%20is%20Human%201999%20%20report%20brief.pdf

IOM. (2001). Crossing the quality chasm: A new health system for the 21st century. *National Academy of Sciences*. Retrieved from http://iom.edu/~/media/Files/Report%20Files/2001/Crossing-the-QualityChasm/Quality%20Chasm%202001%20%20report%20brief.pdf

Kalman, C. J. (2010). Handover in the perioperative care process. *Current Opinion in Anesthesiology*, 23, 749.

Leblanc, J., Donnon, T., Hutchison, C., & Duffy, P. (2014). Development of an orthopedic surgery trauma patient handover checklist. *Canadian Journal of Surgery,57*(1), 8-14. doi:10.1503/cjs.025912

Lock, D. (2017, November 01). Kurt Lewin's Change Model. Retrieved from http://daniellock.com/kurt-lewin-change-model/

Meisel, Z. F., & Smith, R. J. (2015). Talking back: A review of handoffs in pediatric emergency care. *Clinical Pediatric Emergency Medicine,16*(2), 76-82. doi:10.1016/j.cpem.2015.04.003

Melnyk, B. & Fineout-Overholt, E. (2011). *Evidence-Based Practice in Nursing & Healthcare:*

A Guide to Best Practice. 2nd ed. Philadelphia: Lippincott Williams & Wilkins.

Moran, K., Burson, R., & Conrad, D. (2016). *The doctor of nursing practice scholarly project: A framework for success*(2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Nagpal, K., Abboudi, M., Manchanda, C., Vats, A., Sevdalis, N., Bicknell, C., . . . Moorthy, K. (2013). Improving postoperative handover: A prospective observational study. *The American Journal of Surgery,206*(4), 494-501. doi:10.1016/j.amjsurg.2013.03.005

Pallant, J. (2016). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*(6th ed.). Maidenhead: Open University Press/McGraw-Hill.

Patton, L. J., Tidwell, J. D., Falder-Saeed, K. L., Young, V. B., Lewis, B. D., & Binder, J. F. (2017). Ensuring safe transfer of pediatric patients: A quality improvement project to standardize handoff communication. *Journal of Pediatric Nursing,34*, 44-52. doi:10.1016/j.pedn.2017.01.004

Petrovic, M. A., Aboumatar, H., Scholl, A. T., Gill, R. S., Krenzischek, D. A., Camp, M. S., . . . Martinez, E. A. (2015). The perioperative handoff protocol: Evaluating impacts on handoff defects and provider satisfaction in adult perianesthesia care units. *Journal of Clinical Anesthesia,27*(2), 111-119. doi:10.1016/j.jclinane.2014.09.007

Project Detail – Hand-off Communications Project. (2013). *The Joint Commission*. Retrieved from http://www.jointcommission.org/toc.aspx

Pukenas, E. W., Dodson, G., Deal, E. R., Gratz, I., Allen, E., & Burden, A. R. (2014). Simulation-based education with deliberate practice may improve intraoperative handoff skills: a pilot study. *Journal of Clinical Anesthesia,26*(7), 530-538. doi:10.1016/j.jclinane.2014.03.015

Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. *Clinical Nurse Specialist,27*(1), 19-25. doi:10.1097/nur.0b013e3182777011

Riesenberg, L., Leitzsch, J., & Cunningham, J. (2010). Nursing handoffs: A systematic review of the literature. *American Journal of Nursing, 110*(4), 24-34.

Robins, H. (2015). Handoffs in the postoperative anesthesia care unit: Use of a checklist for transfer of care. *AANA Journal,83*(4), 264-268.

Schein, E. H. (1999). Kurt Lewin's change theory in the field and in the classroom: Notes toward a model of managed learning. *Systems Practice,9*(1), 27-47. doi:10.1007/bf02173417

Schindler, L., & Lapiz-Bluhm, M. D. (2013). Collaborative student-led initiative to improve handoff report between emergency and medical-surgical departments. *Journal of Nursing Practice Applications & Reviews of Research,4*(1), 28-37. doi:10.13178/jnparr.2014.0401.1219

Sears, K. Shannon, T., Craddock, M. D., Flowers, B., & Bovie, L. (2014). The evaluation of a communication tool within an acute healthcare organization. *Journal of Hospital Administration, 3*(5), 79-87.

Segall, N., Bonifacio, A. S., Schroeder, R. A., Barbeito, A., Rogers, D., Thornlow, D. K., . . . Mark, J. B. (2012). Can we make postoperative patient handovers safer? A systematic review of the literature. *Anesthesia & Analgesia, 115*(1), 102-115.

Seifert, P. C. (2012). Implementing AORN recommended practices for transfer of patient care information. *AORN Journal, 96*(5), 475-493.

Shirey, M. (2013). Lewin's theory of planned change as a strategic resource. *Journal of Nursing Administration, 43*(2), 69-72.

Staggers, N., & Blaz, J. (2012). Research on nursing handoffs for medical and surgical settings: an integrative review. *Journal of Advanced Nursing, 69*(2), 247-62.

Streeter, A. R., & Harrington, N. G. (2017). Nurse handoff communication. *Seminars in Oncology Nursing,*1-8. doi:10.1016/j.soncn.2017.10.002

Sullivan, E. J. (2012). *Effective leadership and management in nursing* (8th ed.). Pearson.

Taylor, J. S. (2015). Improving patient safety and satisfaction with standardized bedside handoff and walking rounds. *Clinical Journal of Oncology Nursing,19*(4), 414-416. doi:10.1188/15.cjon.414-416

The Joint Commission. (2017, September 12). Inadequate hand-off communication. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf

Weingart, C., Herstich, T., Baker, P., Garrett, M. L., Bird, M., Billock, J., . . . Bigham, M. T. (2013). Making good better: Implementing a standardized handoff in pediatric transport. *Air Medical Journal,32*(1), 40-46. doi:10.1016/j.amj.2012.06.005

Welsh, C., Flanagan, M., & Ebright, P. (2010). Barriers and facilitators to nursing handoffs: Recommendations for redesign. *Nursing Outlook, 58*(3), 148-54.

White-Trevino, K., & Dearmon, V. (2018). Transitioning Nurse Handoff to the Bedside. *Nursing Administration Quarterly,42*(3), 261-268. doi:10.1097/naq.0000000000000298

Wollenhaup, C. A., Stevenson, E. L., Thompson, J., Gordon, H. A., & Nunn, G. (2017). Implementation of a modified bedside handoff for a postpartum unit. *The Journal of Nursing Administration,47*(6), 320-326. doi:10.1097/nna.0000000000000

Younan, L. A., & Fralic, M. F. (2013). Using “Best-Fit” Interventions to Improve the Nursing Intershift Handoff Process at a Medical Center in Lebanon. *The Joint Commission Journal on Quality and Patient Safety,39*(10). doi:10.1016/s1553-7250(13)39059-x