Improving Emergency Department Handoff Presentation

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SUMMARY

What is Bedside Handoff? The transfer or "handoff" of pertinent information from one healthcare staff member to another in a standardized format at the bedside. Handoff includes discussion of patient specific information, transfer of responsibility and accountability for the patient's care. Handoff includes an opportunity to ask questions, clarify and confirm.

The transfer of care of Emergency Department(ED) patients is a high risk event and more handoffs occur in the ED than anywhere else in the Hospital. The Joint Commission recognizes that a critical patient safety problem in healthcare is ineffective handoff communication. Up to 80% of serious errors and sentinel events in hospitals are caused by miscommunication, of which handoff errors are a leading source. As a result, the Joint Commission began requiring that accredited organizations use a standardized approach to handoff communications. The purpose of this project is to improve patient handoff for registered nurses and patient care technicians in Nuvance Health's Danbury and New Milford Hospital Emergency Departments.

EDUCATIONAL OBJECTIVES

1. Standardize the communication process to ensure a consistent quality experience for patients and decrease the potential of near misses.
2. Describe the role and value of bedside handoff in improving patient safety in the emergency department.
3. Identify strategies to improve handoff communication at the bedside and allow for an interactive exchange between the caregivers and patients/families.
4. Increase compliance of staff with bedside handoff.

INTRODUCTION

Background

A handoff is the transfer of information during transitions in care, across the continuum. Effective handoff includes opportunities to ask questions, clarify information and confirm details, responsibilities and next step.

The ENA (Emergency Nurses Association) position statement states the impact of ineffective handoffs includes such adverse events as delays in diagnosis and treatment, fragmented care, breaches in care, medication errors, conflicting communication, duplication of procedures and tests, lover provider and patient satisfaction, higher costs, longer and more frequent hospital stays, and patient deaths.

The problem

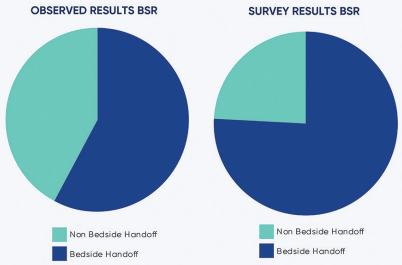
The problem is inconsistency with performing handoff at the bedside and recognizing handoffs as a critical patient safety issue.

METHODS

A direct observation tool was developed to measure location (bedside, hallway or nurses' station)of the verbal handoff and which handoff method staff utilize when giving handoff report. This examination method examined duration and location of handoff and stakeholders involved to test the theory that bedside handoff is a proven safe practice4 for out patients. An online survey was emailed to all staff to complete. Direct one-to-one feedback was provided to discuss and compare the impact of handoff at the bedside. Qualitative data revealed time restraints and distractions as deficiencies in infrastructure to support handoffs at the bedside.

OUTCOMES

The results of direct observation of Bedside Shift Report (BSR) audit review survey data indicated 58% of staff perform handoff at the bedside and 42% do not perform bedside handoff. Results from the online survey indicated improvement in bedside handoff, 76% of staff stated they perform handoff at the bedside and 24% do not perform handoff at the bedside.



CHALLENGES

Evaluation of current methods being used to perform bedside handoff have shown inconsistency with performing BSR. The handoff methods used at Danbury and New Milford EDs to perform handoff at the bedside include SBAR, TeamSTEPPS, and I-PASS which are standardized patient handoffs. The need for staff to mentor each other and perform handoff at the bedside would be most beneficial to the patient and improve patient safety.

Staff verbalized concern regarding sensitive issues and were encouraged to address sensitive matters outside of patient room such as:-

- Discuss any sensitive matters that may upset patient/family if provider has not already notified (i.e. possible cancer diagnosis)
- Discuss possible psychological/psychosocial issues (need for mental health evaluation, referral to social services)that may agitate patient or family.
- Discuss any other information that may be appropriate for the shift assignment (i.e. barriers to care, task performance, documentation)

NEXT STEPS

The Joint Commission recognizes and supports the literature in utilizing standardized patient handoffs and transfer methods that reduce risk to patients. More education is needed for staff on BSR to emphasize the vital necessity of handoffs for patient safety and integration into nursing practice. There is a lack of robustly designed studies examining the impact of nursing handoff interventions. Additional research is needed to provide empirical evidence on the handoff process, and for more meticulous studies of nursing handoff interventions.

Future education involves requiring all staff attend effective communication training such as TeamSTEPPS to enhance communication with patient/families and work together to shift culture to create a culture of safety and improve efficiency to facilitate optimal performance.

Additional steps include review of handoff at our sister hospitals in Nuvance and identification of which standardized patient handoff tool works best to achieve out goals and provide the best care and outcomes for our patients.

REFERENCES

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