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Patient Hand-Off

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PATIENT CARE ISSUE

During a patient 's stay in the hospital, many nurses will be involved in that patient's care. It is vital that nurses communicate well during change-of-shift report to ensure quality and continuity of care.

According to the Joint Commission Center for Transforming Healthcare (1)**:**

- **80% of serious medical errors occur due to miscommunication between health care providers when patient responsibility is handed-off**
- **The Hand-off Communications Project found that over 37% of handovers were defective and did not allow the receiver to safely care for the patient**
- **Defective hand-off can lead to patient harm, delayed or improper treatment, and increased length of hospital stay**

1. Zhani, E. E. (2010, 10 21). Joint commission center for transforming healthcare tackles miscommunication among caregivers: Top U.S. hospitals identify causes, develop targeted solutions to save lives. Retrieved from http://www.centerfortransforminghealthcare.org/news/detail.aspx?ArticleId=293994

EVIDENCE-BASED PRACTICE QUESTION

Question: For a patient on an inpatient unit, will bedside hand-off report with a standardized tool, as compared to traditional hand-off report, improve patient safety and care?

P: patients and nurses on inpatient care units in hospitals
I: bedside hand-off and a standardized nurse-to-nurse report protocol to ensure that hand-offs are efficient and important information is communicated
C: comparison of interventions reveals: bedside hand-off and report standardization benefits patients, nurses, and quality of care
O: effective communication at change-of-shift to promote safety, optimal care, and satisfaction among nurses, patients, and family members

REGISTERED NURSE INTERVIEW

Amanda of Miami Valley Hospital and Corinne of Grandview Hospital, both in Dayton, confirmed that their hospitals practice bedside change-of-shift report, although neither was clear on their hospital's exact policy or the specifics of the evidence base. They find bedside report useful because it gives the oncoming nurse a chance to assess the patient's situation and see what needs to be done first. However, Corinne noted that this ideal practice is not always implemented in reality. Neither nurse used a standardized hand-off form to guide report, but Amanda did mention that nurses print out their "brain," a template of the most important patient information, which they take notes on during report.

METHODS

A number of keywords were searched on the databases AMED, CINAHL, Medline, and PubMed. The keywords were: patient handoff report, bedside report, change of shift report, nurse communication, and change of shift report.

Inclusion criteria: published in the last five years in the U.S., Canada, or Australia.

Exclusion criteria: articles focusing on outpatient settings or maternity wards.

RESULTS

Main point: Effective clinical handover is a national patient safety goal in the USA.

Factors that cause risks/get in the way of this goal (3)**:**

- **Reports often only verbal and lack clarity**
- **Lack of structure in reporting style**
- **Tendency for information overload**

Things that can be done to reach this goal:

- **Active communication to allow mentoring and team-building** (4)
- **Two-way face-to-face communication at patient's bedside** (3)
- **Give handover at correct time, not during meals or breaks** (6)
- **Written support tools and content that captures intention** (3)
- **Reports be goal-focused, thorough, rapid, and brief** (2)
- **Make expectations on both sides clear** (2)

2. Dufault, M., Duquette, C. E., Ehmann, J., Hehl, R., Lavin, M., Martin, V., Moore, M. A., Sargent, S., Stout, P., & Willey, C. (2010). Translating an evidence-based protocol for nurse-to-nurse shift handoffs. Worldviews on evidence-based nursing 2010; 7(2):59-75.

3. Hill, W., & Nyce, J. (2010). Human factors in clinical shift handover communication: review of reliability and resilience principles applied to change of shift report. Canadian journal of respiratory therapy, 46(1), 45, 48, 50.

4. Jukkala, A.M., James, D., Autrey, P., Azuero, A., & Miltner, R. (2012). Developing a standardized tool to improve nurse communication during shift report. Journal of nursing care quality, 27(3), 240-246. doi: 10.1097/NCQ.0b013e31824ebbd7

5. Riesenberg, L. A., Leitzsch, J., & Cunningham, J. M. (2010). Nursing handoffs: A systematic review of the literature. American journal of nursing, 110(4), 24, 27, 28, 31.

6. Scovell, S. (2010). Role of the nurse-to-nurse handover in patient care. Nursing standard. 24, 20, 35-39. Date of acceptance: September 25, 2009.

SYNTHESIS OF EVIDENCE

Main findings to improve nursing handoff reports:

- **Checking patients actively and being physically present at bedside for report** (8)
- **Increasing nurse-to-nurse accountability** (7)
- **Increasing patient involvement** (7)
- **Using SBAR more efficiently** (8)

7. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside nurse-to-nurse handoff promotes patient safety. Medsurg Nursing, 21(3), 140-146. Retrieved from http://web.ebscohost.com/ehost/detail?vid=7&hid=108&sid=6a96b16e-634c-4a0a-8b7f-45e98fb8a818@sessionmgr115&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ== (Maxson, Derby, Wrobleski & Foss, 2012)

8. Street, M., Eustace, P., Livingston, P.M., Craike, M. J., Kent, B., & Patterson, D. (2011). Communication at the bedside to enhance patient care: A survey of nurses' experience and perspective of handover. International journal of nursing practice, 17, 133-140, doi: 10.1111/j.1440-172X.2011.01918.x (Street, Eustace, Livingston, Craike, Kent & Patterson, 2011)

EVIDENCE-BASED PRACTICE RECOMMENDATIONS

Always allow nurse receiving report the chance to ask questions
Consistent order of information
Practice bedside handoffs
Use a standardized tool
IOWA Model was used

LIMITATIONS

Hawthorne Effect most likely present
Not many statistical values
Levels of Evidence too low
Little empirical data
Wide population