11-2012

Patient Hand-Off

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Recommended Citation
Cuddington, Amy and Johnson, Olivia, "Patient Hand-Off" (2012). Pharmacy and Nursing Student Research and Evidence-Based Medicine Poster Session. 17.
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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


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)

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.

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

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.

SYNTHESIS OF EVIDENCE
Main findings to improve nursing handoff reports:
• Checking patients actively and being physically present at bedside report (8)
• Increasing nurse-to-nurse accountability (7)
• Increasing patient involvement (7)
• Using SBAR more efficiently (8)


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