

IMPROVING NURSING HANDOFF

Yuan Yuan Liu, RN, BSN

UCSF Medical Center

Contact Email Address: yuanyuan0719@hotmail.com

Purpose:

The purpose of this project is to improve nursing handoff in a cardiovascular-thoracic unit by creating and implementing a unit specific template in the electronic documentation system. PICO question: What is the effect of a computerized handoff tool in a cardiovascular-thoracic unit in improving nursing handoff satisfaction and reducing medication errors?

Background and Evidence Review

Complete and accurate handoff is important for patient safety. Initial practice for shift to shift handoff on the unit was done using a paper form. However, the form was not consistently used by all staff, and was missing important elements. A standardized process was not consistently followed for 2-RN independent check of continuous medication infusions at change of shift. Very limited research showed best practice for nursing handoff format. A computerized handoff tool was recommended due to standardization, ease of use, and time savings.

Methods

With assistance from IT and Nursing Informatics, a unit specific computerized handoff template was created and implemented. The standardized process of the 2-RN independent check of continuous medication infusions was re-introduced. Ten “champions” assisted with staff education and training. A nursing satisfaction survey was conducted before and after the handoff tool was implemented. An audit tool was created and used to measure medication errors for continuous medication infusions pre and post staff education.

Results

After implementing the new handoff process 92% of the staff agree that when getting a handoff report on a patient with a continuous medication infusion, they usually get all the information they need, in comparison to 78% when they were using the paper form. Errors for continuous medication infusions decreased pre to post from one to zero. Deviation from compliance with policy related to infusions was found in the audits, which improved

after staff re-education of the 2-RN independent check process.

Conclusion

Given the results from this project, this computerized handoff tool will continue to be used on our unit. Six other units in the hospital have been successfully using a computerized handoff tool as well. Next steps may include spreading the practice to other units. Challenges of this project included some nurses' reluctance towards change and new innovation, and staff tendency to verbally repeat everything in the handoff report rather than giving only additional verbal information (can result in longer handoff time). Also, a main dissatisfier for staff was the inability to change the formatting of the handoff template. Completing 2-RN independent checks during shift change still needs to be reinforced.

Selected References:

1. Riesenber, L.A., Leisch, J., Cunningham, J.M. (2010). "Nursing handoffs: a systematic review of the literature." Am J Nurs 110(4): 24-36.
2. Shendell-Falik, N., Feinson, M., Mohr, B.J. (2007). "Enhancing Patient Safety: improving the patient handoff process through appreciative inquiry." J Nurs Adm 37(2): 95-104.
3. Welsh, C.A., Falanagan, M.E., Ebright, P. (2010). "Barriers and Facilitators to nursing handoffs: Recommendations for redesign." Nurs Outlook 58(3): 148-54.

Key Words:

Nursing Handoff, Improve Nursing Handoff, Best Practice for Nursing Handoff, Computerized Nursing Handoff