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Standardized Bedside Handoff: One Organization's Journey☆·☆☆

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In 2006, the Joint Commission established a National Patient Safety Goal that addressed hand-off communication, making the standard a requirement in 2010. The standard, Provision of Care Standard PC.02.02.01, element of performance 2, requires that: The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information (The Joint Commission, 2017, September 12). In September 2017, the Joint Commission issued a Sentinel Event Alert related to errors from inadequate patient hand-offs (The Joint Commission, 2017, September 12). This Sentinel Event Alert described the common underlying causes of an inadequate patient hand-off, and recommended steps to reduce the risk and prevent future occurrences of this event. When a Sentinel Event Alert is released it is imperative that accredited organizations consider implementing the relevant suggestions contained within the alert or a reasonable alternative in order to prevent the sentinel event from occurring.

Inadequate hand-off communication is a contributing factor to numerous adverse events, including many types of sentinel events. According to The Joint Commission's sentinel event database inadequate hand-off communication has been responsible for adverse events, including wrong-site surgery, delay in treatment, falls, and medication errors (The Joint Commission, 2017, September 12). A study released in 2016 estimated that communication failures in U.S. hospitals and medical practices were responsible at least in part for 30% of all malpractice claims, resulting in 1744 deaths and $1.7 billion in malpractice costs over five years (The Joint Commission, 2017, September 12). Ineffective hand-off communication is recognized as a critical patient safety problem with 80% of serious medical errors involving miscommunication between caregivers during the transfer of patients. It is estimated that a typical teaching hospital experiences more than 4000 hand-offs each day (The Joint Commission, 2017, September 12). This purpose of this article is to discuss the work that Children's Mercy Kansas City has done to address the ongoing issues related to gaps in communication that lead to increased patient safety risks.

Historically, Children's Mercy Kansas City had encountered barriers to standardizing nurse shift change handoff, such as variability in information that was shared from nurse to nurse and the inability to sustain efforts to standardize nurse to nurse report. Although multiple units had successfully implemented bedside handoff, there was significant variation in the handoff process from nurse to nurse. The inconsistencies included: topics discussed, information shared inside and outside of the patient's room, content, use of the electronic medical record, inclusion of safety checks, and involvement of patient and family members in the shift handoff. Learning from previous unsuccessful efforts and utilizing Lean Methodology, we took a new approach to understanding the issues including pre-assessment and stakeholder planning via a rapid process improvement workshop (RPIW) to develop and execute tools and processes for sustainability (Graban, 2017). The Lean Methodology is a method that facilitates the improvement of safety, quality, access and morale while reducing an organization's costs, increasing their capacity, and ultimately strengthening their bottom line (Graban, 2017). The RPIW focused on developing and spreading a standardized bedside handoff process to all medical/surgical units to ensure that standard content is discussed with the patient/family at the bedside.

Nurses working in small groups focused on developing a standardized bedside handoff process that included patient and family engagement, communication/education, a sequential flow, and metrics to facilitate the process. The Joint Commission (2017) recommended seven actions to mitigate errors related to inadequate hand-offs. We offer our experience at Children's Mercy as an example of how we implemented the following strategies to address each of these seven actions/recommendations.

1. *Demonstrate leadership's commitment to successful hand-offs and other aspects of safety culture.*
   A Department of Nursing strategic plan sponsored by the chief nurse officer (CNO) was established to use the Lean Methodology to reduce the variation in hand off methods and create a standardized hand off method across the institution that will ultimately improve the quality and safety of patient care. This process was completed in phases. The first phase was to establish a standard for the medical/surgical nurse to nurse shift hand-off. The next phase was to develop a standardized hand off between interdepartment transfers with the departments who had the highest numbers of incidents related to hand-off issues. A systematic plan of action was established that used the same Lean Methodology components for planning, workshop, and sustainment strategies for each of these areas.

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2. *Standardize critical content to be communicated by the sender- verbal and written. Use of standardized tools to communicate.*
   Standardized tools were created for the sender and receiver to use for the standardized bedside handoff from the outgoing medical/surgical nurse to the oncoming medical/surgical nurse (See Fig. 1). In addition, specialized tools were developed to facilitate the handoff of care from the bedside nurse to nurses in specialty areas and for the specialty area nurses to give handoff report back to the bedside nurse (see Figs. 2 and 3). Each of these individual standardized tools was developed with the goal of facilitating the ease of use and reducing variation when applying to a specific hand-off type.
3. *Conduct face-to-face hand-off communications in locations free from interruption. Include patients and family.*
   In order to facilitate family engagement, the face to face hand-off of care occurred at the bedside with the patient and family present. The institution developed tools were designed to include prompts that remind the staff to engage the patient and family in the hand-off process.
4. *Standardize training on how to conduct a standardized hand-off.*
   A standard process was developed for each of the giver and receiver hand-offs. Training was conducted prior to roll-out of each of the individual hand-off tools. The Lean Methodology was used to help facilitate this process. The Lean Methodology principle of doing a confirmation of the correct process was designed into the process to ensure that the new standard was consistently followed. Each employee was assigned to a unit leader, charge nurse or unit education coordinator who would watch the nurse to nurse hand-off and confirm that it was performed according to the new standard. This data was posted and tracked for the staff to view.
5. *Use electronic health record capabilities to enhance hand-offs.*
   All of the hand-off tools that were created directed the staff to refer to the electronic health record for specific patient information. The standard work for the "sender" and "receiver" directs the nurse to log into electronic health record.
6. *Monitor the success of interventions to improve hand-off communication and use the results to drive improvement.*
   To assess the success of the standardized hand-offs, a K-card auditing process was developed to monitor the compliance of the outlined hand-off process (see Fig. 4). An abnormality tracker was used to understand deviations from the process, which helped to identify and drive changes for improvement.
7. *Sustain and spread best practices in hand-offs and make high-quality hand-offs a cultural priority.*
   The standardized hand-offs were implemented in July 2016 with the medical/surgical nurses conducting the standardized shift to shift hand off of care. These standardized hand-offs have now spread throughout the organization with the Emergency Department to Inpatient hand-off going live in March 2017; Post Anesthesia Care Unit (PACU) to Inpatient live in February 2018; and Inpatient to Radiology handoff going live in June 2018. The Pediatric Intensive Care to inpatient hand-off will go live in November 2018 with the next focus area for handoff work will be the Intensive Care Nursery.

As a result of the standardization of shift hand-off, there have been fewer incidence of errors related to a breakdown in communication from inadequate shift hand-off. In addition this work has had a significant impact on reducing the number of incident reports related to transitions in care at Children's Mercy. It is imperative that Children's Mercy continues to focus on providing safe and efficient transitions in care for our patients. To continue on our path to providing safe care to our patients we want to develop communication triggers during the nurse to nurse hand-off process that will loop in providers and ancillary staff

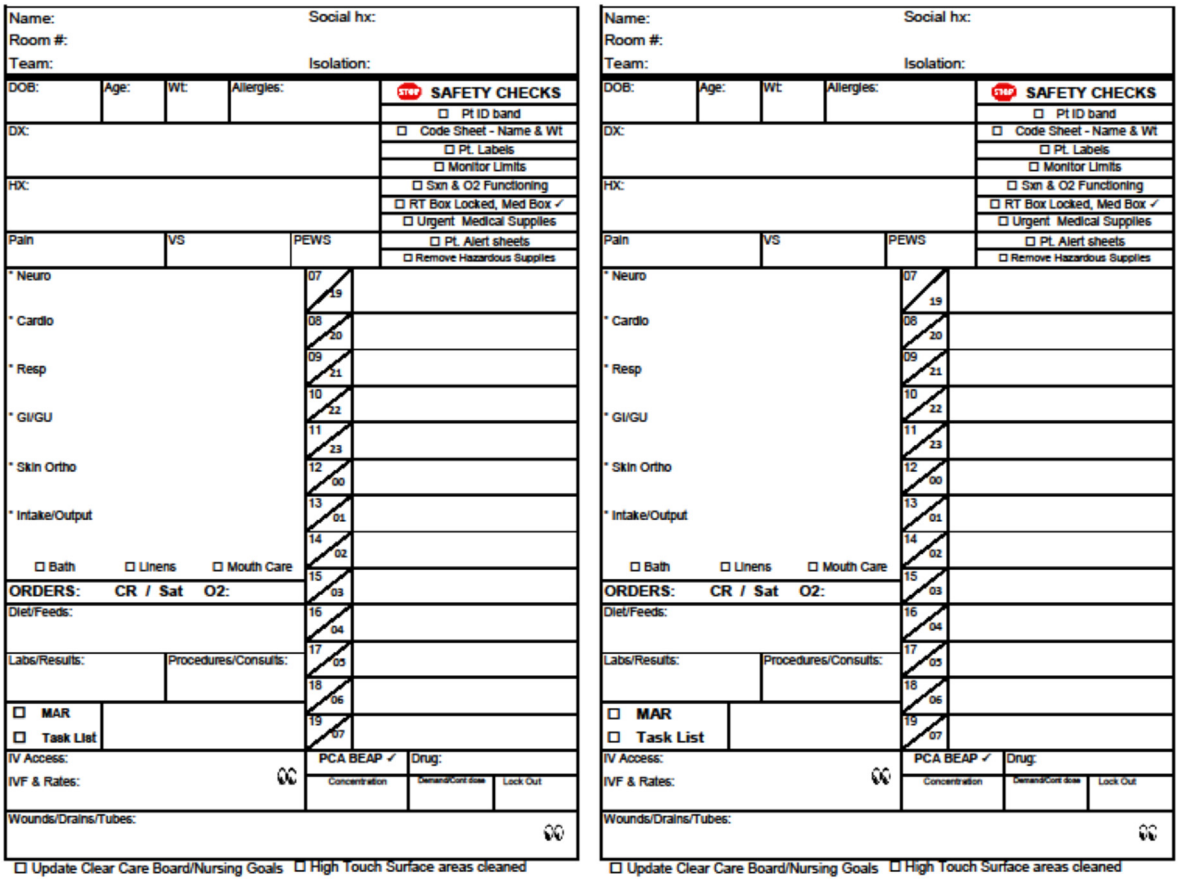

Fig. 1. Nurse bedside report tool that nurses use when giving change-of-shift report.

Inpatient RN: **Time PITCH Initiated:** **Time PITCH Complete:**	
Name/DOB:	O2/Suction Needs: IV Pump:
Inpatient Floor and Room #:	Mode of Transportation:
Social/Behavioral Hx:	Isolation: 1-1:
Interpreter Needed? Y or N Language:	Monitors: CR: O2 Sat:
Are continuous cardio/respiratory monitors ordered? Y or N	
If yes- Which nurse will stay with Patient? Floor RN or Transport RN (15995) or Sedation RN (16038)	
Medication infusing/ required while in Radiology?	
Urgent Medical Supplies Check 👀	
Nuclear Medicine	**MRI**
IV: Y or N location: Gauge:	IV: Y or N
Port PICC Hickman power injectable: Y or N	Pt. wearing: street clothes or hospital attire
UCG: NPO status:	UCG: NPO status:
Medications	Implanted Devices:
Parent Present: 👀	Parent Present: 👀
CT	**Ultrasound**
IV: Y or N location: Gauge:	NPO status:
Port PICC Hickman power injectable: Y or N	**Fluoroscopy**
UCG Flow rate:	UCG: NPO status:
Parent Present: NPO status:	Parent Present:
Interventional Radiology	**Anesthesia required : Y or N**
UCG: NPO status:	**Sedation Hours:**
Parent Present: 👀	**Weekday: 0600-2100**
Consent obtained:	**Weeknights: 2100-0600 (on call)**
	Weekends: 0700-1900 (limited availability)
Estimated time of procedure:	**Duration of procedure:**

Fig. 2. Hand-off tool used between radiology and the nurse when patients go to radiology for a procedure.

Receiving RN: **Time PITCH Initiated:** **Time PITCH Complete:**			
Name:		PEWS: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5 ☐	
Age:		O2: ☐ Yes ☐ No	Trach supplies: ☐ Yes ☐ No
Admitting Dx:		Other: ☐ Yes ☐ No	
Isolation: ☐ Yes ☐ No	Language Needs:	Transportation Needs: ☐ Yes ☐ No	
1-1: ☐ Yes ☐ No	☐ Yes ☐ No	Pickup Delivery **(please circle)**	
Social Concerns: ☐ Yes ☐ No		**Handoff Time:**	**Room Ready:** ☐ **Yes** ☐ **No**
Face-to-Face  **(Introduce Family & Explain handoff process)**			
STOP **ID/Allergy Band** 👀 DOB: Allergies:		Weight:	
Dx:			
Hx:			
Pain:	VS (Last Set/Range):		
PEWS:			
FOCUSED ASSESSMENT INTERVENTIONS	*Neuro:		**NA** ☐
	*Cardio:		**NA** ☐
	*Resp:		**NA** ☐
	*GI/GU:		**NA** ☐
	*Skin/Ortho:		**NA** ☐
☐ MAR	☐ Labs ☐ Radiology	☐ Orders ☐ Consults	
IV: Site Rate 👀		Wounds/Tubes: 👀	
Parent Questions/Needs:			
☐ Urgent Medical Supplies Check 👀			

Fig. 3. Hand-off tool used by the Emergency Department nurse to the medical/surgical nurse for patient admission.

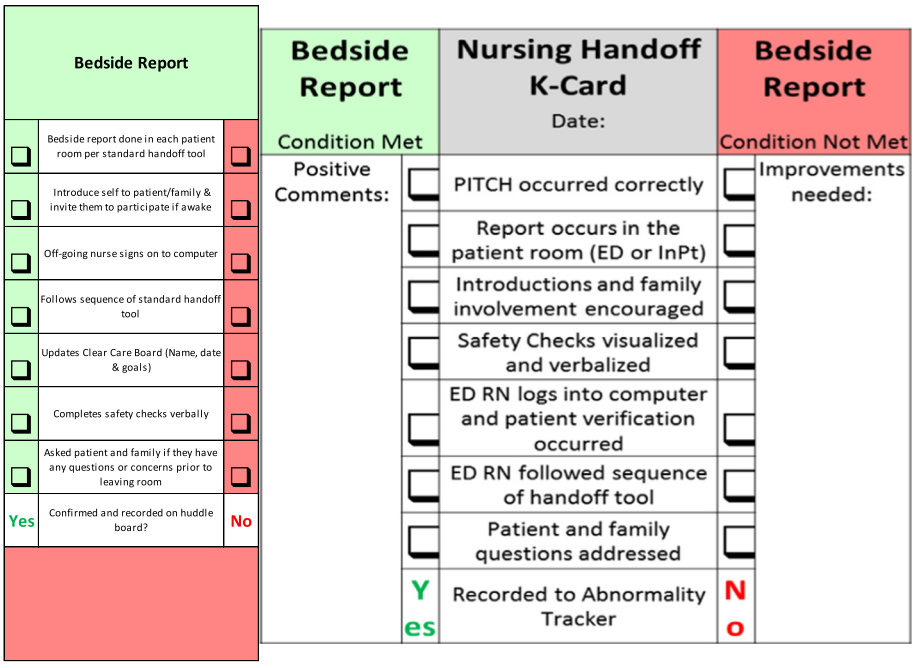

Fig. 4. Kamishibai cards (k-cards) used to facilitate conversation and tracking regarding adherence to the elements of the hand-off process. The one on the left is for bedside report and on the right ED to inpatient hand-off.

on pertinent patient information that they would need to know to better care for our patients. To ensure that we sustain this practice change, we want to develop a structured cadence to evaluate the sustainment of the various hand-off processes. Using the actions recommended by The Joint Commission, Children's Mercy was able to develop standards related to effective communication flow between nurses during patient hand-off, an essential process to safe guard our patients.

Acknowledgment

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References

Graban, M. (2017). *Lean hospitals: Improving quality, patient safety, and employee engagement* (3rd ed.). Boca Raton: Taylor & Francis.

The Joint Commission (2017, September 12). Sentinel Event Alert 58: Inadequate hand-off communication. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf.