

Monitoring handoffs for standardization

By Kathy Mikos, RN, CNO, MSN

A 2005 study of sentinel events reported to The Joint Commission by accredited health-care organizations revealed that a staggering 70% resulted from communication problems. Studies show that at least half of these communication breakdowns occur during patient handoffs.¹

Handoffs take place during the busiest and most stressful times in a hospital, creating endless opportunities for the loss of important details between caregivers. The time constraints of these periods make it difficult to communicate the volume of information necessary to ensure an adequate transfer of care. Communication is also hindered by the variety of methods used, differing communication styles, interruptions, and rushed reporting.

The Joint Commission now requires a standardized reporting template for handoffs. Expectations note that hospitals should limit interruptions, allow sufficient time for communication, and include a process for verifying information between caregivers. The Joint Commission also emphasizes the importance of monitoring and performance improvement activities to ensure ongoing compliance.

Since the release of these expectations, hospitals have been searching for methods to facilitate the timely and accurate transfer of information

that ensures patient safety and quality of care. At Provena Saint Joseph Medical Center (PSJMC), Mokena, Ill., we've used handoff technology to standardize and monitor these handoffs.

1. Establish goals. The team started with an in-depth review of PSJMC's existing processes for handoffs by unit and type. Shift-to-shift reporting and patient transfer were identified as the periods of highest priority. Over the years, the hospital had tried a variety of methods for handoffs, including tape recordings, phone and hand-written reports, and face-to-face exchanges. Each one had its own set of obstacles.

An overarching concern was that our existing handoff methods lacked any capability for monitoring or quality improvement. Without a mechanism to gauge the accuracy and consistency of our handoffs, we were unable to measure compliance or identify training needs among staff.

After an analysis of the gaps in our existing handoff methods, we established goals for a new solution. Our objective was to design a handoff methodology that would improve quality and patient safety by standardizing handoff communication across our facility. We also wanted to increase efficiency and reduce costs related to incremental overtime. In meeting these objectives, it was critical to ensure com-

pliance with The Joint Commission's standards for handoffs as communicated in its National Patient Safety Goals.

2. Identify solutions. The team identified voice technology as having the greatest potential for a complete and streamlined report process. Working with an outside vendor, we identified a solution that allowed us to enter and receive reports through a central server accessible by phone. After installing the server in our data center and integrating it with our phone system, we tested the solution on a 55-bed medical unit. Because the technology used a tool that was familiar and readily available on all nursing units, implementation was a smooth and easy process. Training, in fact, took less than 10 minutes per nurse.

To enter a report, the nurse dialed into the system and entered a user PIN and patient ID, then spoke a report for each patient. Instead of waiting until shift change or the time of transfer to enter reports, nurses could conduct reports at any convenient time during their shift. The system could be accessed through any landline or portable wireless phone, giving nurses the flexibility of using a quiet conference room or decentralized area for reporting.

If the patient's status changed or an important detail was omitted,

the nurse could go back into the system and create an addendum to the report prior to the handoff. Another feature was a pause key that allowed nurses to stop and resume while entering or listening to reports. Additional hot keys included options to speed up, slow down, fast forward, and rewind reports. To assist in training, each nurse received a reference card showing access numbers and hot button keys.

3. Standardize content. We were able to accomplish this with the technology by building in prompts that led nurses through the key sections of each report. Following The Joint Commission's recommendation for standardizing handoffs, we customized our prompts to follow the SBAR (situation, background, assessment, recommendation) communication model. (See "SBAR communication model.") Forms were distributed to educate nurses on the verbal responses that should be communicated for each recorded prompt.

Prompts could be customized by unit if certain floors needed to report on additional issues. A prompt for code status, for example, was added for high-risk patients so nurses would know what to do in the event of cardiac or respiratory arrest. Management has also considered adding a prompt for discharge plans so that caregivers are kept aware of these plans across the continuum of care.

The standard format ensured that all members of the care delivery team had common expectations for the required elements of a handoff, the information that should be communicated, and the structure for that information. This consistency was critical for conducting handoffs that resulted in high-quality, safe

care for the patient.

4. Apply facility-wide. After a month of testing the phone-based system, we applied the solution across the entire hospital as the standard for handoff reporting. The user-friendly technology ensured that even agency nurses, float nurses, students, and new hires could easily access the system with a user ID and PIN.

At least 1 hour prior to shift change, nurses in the outgoing shift enter their reports through the phone-based system. Shifts continue to overlap by 30 minutes, with incoming nurses receiving their assignments and immediately listening to applicable patient reports. During this time, the outgoing shift is free to continue direct patient care by responding to call lights, giving medication, and

receiving any admissions. In the next 15 minutes, nurses have the opportunity to clarify handoffs by asking and responding to questions. Because face-to-face time is now more efficient, the outgoing shift is able to leave at the scheduled time.

The patient transfer process begins when the unit receives the physician's order for transfer. Once the bed assignment is determined, the nurse enters the handoff report in the system. The transferring nurse also leaves a name and contact number for questions or clarifications.

When the report is complete, the nurse calls the receiving unit to let them know the report is available. An upgrade to this process is an alert that automatically notifies the unit of an incoming report through a pager or voice message. The receiving nurse is given 20 to 30

SBAR communication model

Situation

Nurse name and unit
Reporting on (patient name and room number)

Background

Admission diagnosis and date of admission
Pertinent medical history
Brief synopsis of treatment to date
Patient code status (if applicable)
Family/significant other involvement
Isolation and type
Precautions (fall, suicide, seizure, restraints)
Medication reconciliation status

Assessment

Vital signs
Abnormal labs within past 24 hours
Postop day (wounds/dressings/I.V. sites with date)
Mobility (number of staff and lifting device needed)
Mental status
Pain assessment/reassessment (last time pain medication was given)
Physician orders (received, carried out, pending)
Oxygen (yes or no)
Changes from prior assessments (vitals, neurological changes, skin, pain)

Recommendation

Items that require follow-up
State of patient teaching needs
Discharge needs



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minutes to listen to the report and prepare for the patient's arrival. This structured process allows both units to regulate bed flow and set the patient's expectation for the time frame of the transfer.

To continue system expansion, we're working to apply the system among other disciplines such as case management, respiratory therapy, nutrition, physical therapy, and home care. This multidisciplinary approach will help ensure improved care management across the facility.

Physicians can also use the system for handoff situations such as consultations and weekend group coverage. For physician groups and units with fewer nurses, the technology

once a standardized handoff methodology is in place, it should be monitored and modified to ensure its effectiveness. A key benefit to the technology we implemented was that it offered the ability to monitor our handoff process.

Once reports are entered in the phone-based system, they're available in the server for later review. Reports are accessible through a Web-based management tool that can be used to audit the standardization of handoffs across our facility. The tool allows us to sort reports by unit, patient, or caregiver to ensure the consistency of information communicated from one caregiver to the next. We can also

dents, preceptors can use archived reports as a reference and listen to new reports to critique their accuracy and provide feedback. Managers can also use the tool to add new users to the system, adjust access privileges, and assign user PINs.

In monitoring patient handoffs across our facility, we've seen tremendous improvements in patient safety and quality of care as a result of implementing the handoff technology. The phone-based reporting process has standardized our handoffs and ensured our compliance with The Joint Commission's requirements.

The streamlined handoff process has allowed nurses to spend more time in direct patient care, increasing surveillance during shift change. The result has been demonstrated by a reduction in patient falls during shift change and an increase in response time to patient call lights. The impact on patient throughput has also been significant, reducing bottlenecks that resulted from delayed transfers.

The decrease in interruptions and distractions during handoffs has reduced reporting time by nearly 70%, from an average of more than 6 minutes to less than 2 minutes per report. This has had a significant impact on incremental overtime, representing an annual savings of nearly \$120,000. **NM**

REFERENCE

1. Collation of sentinel event-related data reported to The Joint Commission (1995-2005). Available at: <http://www.jointcommission.org/SentinelEvents/Statistics>. Accessed October 25, 2007.

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features a group report that provides a continuous report on each patient. This format is beneficial for hospitalists and units such as labor and delivery, the intensive care unit, and the behavioral health unit.

Another application is using the technology to improve communication with patients' family members by entering phone reports that summarize up-to-date progress. Patients designate individuals authorized to receive reports, who listen to updates by dialing a secure line and entering a unique login. The streamlined process promotes collaboration with families and allows nurses to spend more time in patient care. The system can also be used to record discharge instructions and notes related to the patient's care plan.

5. Monitor and measure results.

The Joint Commission states that

listen to reports to review their quality, clarity, and adherence to SBAR methodology.

This management feature helps us in preparing for tracer methodology by providing valuable information related to the transfer of care for each patient. By producing a report of all handoffs related to a particular patient, we can document patient care from one caregiver to the next across the continuum of care. This ability is also useful in conducting root cause analysis of any unusual occurrence such as a patient fall or complaint.

In addition to report monitoring, the Web application serves as a valuable resource for training and evaluation in handoff competency. Usage reports help us ensure that caregivers are consistently using the technology as the standard method for handoffs. When training new nurses or stu-