Effective Emergency Department Hand-off Report for Nurses

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PROBLEM/BACKGROUND:

In January 2006 JCAHO initiated the national patient safety goal for the potential protection of patients' safety (Friesen et al., 2008). JCAHO's analysis as reported by Wheeler (2015) shows that over 70% of sentinel events occurred because of communication breakdowns between the nurse giving report and the nurse receiving report. Additionally, it was explained that greater than 80% of adverse events are due to poor quality and incomplete hand-off reports by nurses. Wheeler (2015) reported that several studies indicate that incomplete hand-off has been a problem in healthcare for many years. During hand-off some information may be neglected because nurses may perceive some information as insignificant (Wheeler, 2015).

PROJECT PURPOSE:

The purpose of the project is to promote evidence-based practice by developing an effective process during patient transfer to improve the quality of hand-off report from the emergency department (ED) nurse and the medical/surgical unit nurse.

THEORETICAL FRAMEWORK:

The framework for this DNP project was Rosswurm and Larrabee's model for evidence-based practice change. Rosswurm and Larrabee (2019) describe six stages of change used to support and implement-based recommendations in healthcare facilities. The first four stages of this model were utilized in this project. First, the need for change was identified and assessed, problem interventions and outcomes were linked, best practices to address the problem were synthesized, and a practice change was designed.

METHODOLOGY:

The planned DNP project was designed for a large hospital in central Florida. The hospital includes a 30-bed emergency department, multiple medical-surgical units, and specialty care units. As part of the DNP project policies and procedures were developed to improve the hand-off practices between the emergency department and the medical/surgical unit.

IMPLEMENTATION COMPONENTS/PROCESS:

A standardized hand-off tool was developed to use when transferring patients from the ED to the medical/surgical unit. The hand-off tool includes important information for patients with COPD/CHF/DM and pulmonary edema. Hemoglobin levels will be documented for all patients transferring from the ED. Due to an unforeseen crisis at the facility, the planned implementation for an in-service to introduce the hand-off tool to the staff was not done.

EVALUATION PLAN:

Formative evaluation of the hand-off report tool was provided by the project team leader and the medical/surgical and emergency department directors.

IMPLICATION FOR PRACTICE:

Implementing the revised standardized hand-off tool has the potential of reducing delays in patient treatment and providing safety.

REFERENCES:

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