Samford University
Moffett & Sanders School of Nursing

Effective Emergency Department Hand-off Report for Nurses

Joan A. Rhoden DNP(c)

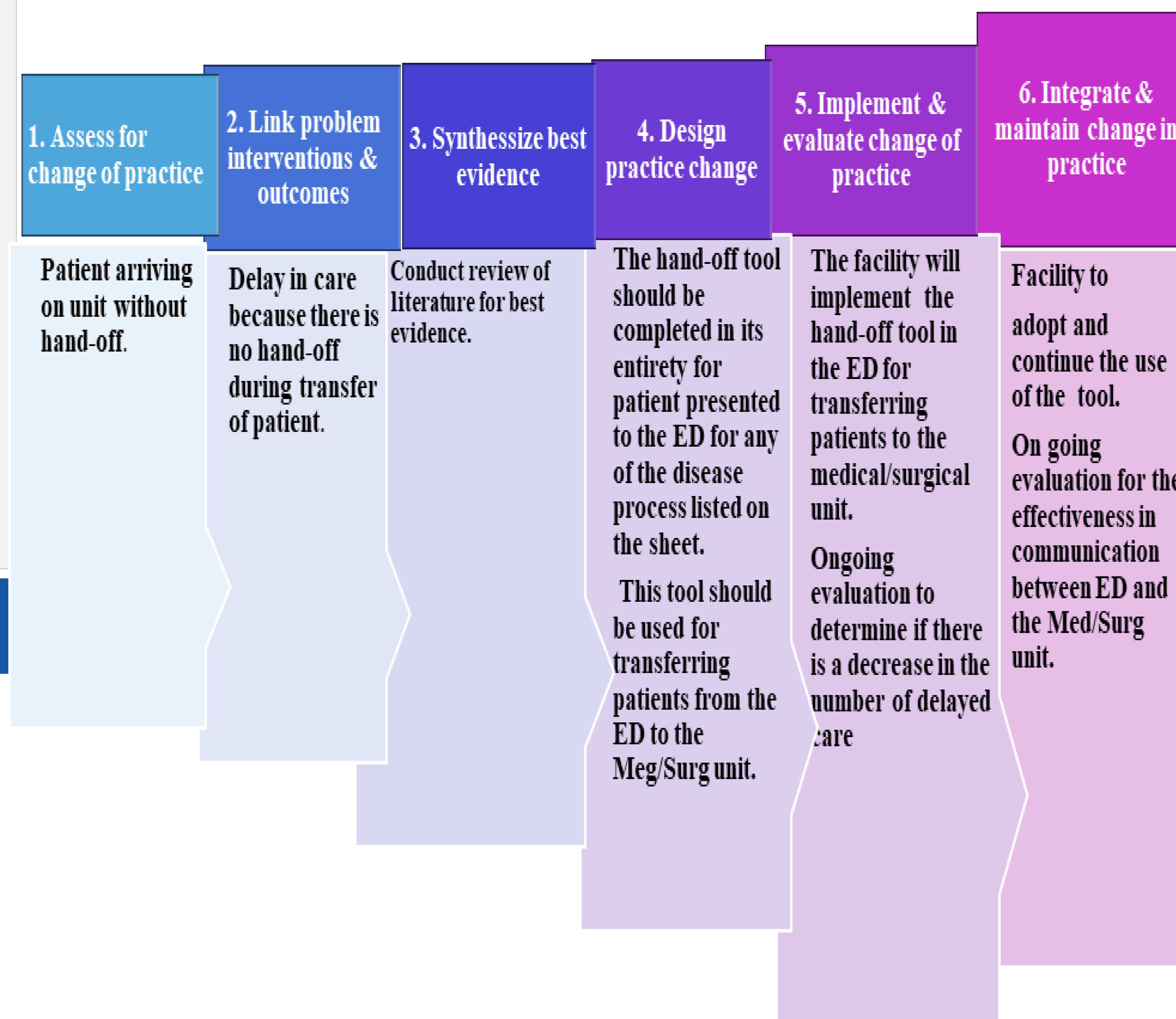
Evidence of Problem

- January 2006 JCAHO initiated patient safety goal
- Analysis completed by Wheeler (2015) indicated that 70% of sentinel events occurred because of ineffective communication
- Communication breakdowns between the nurse giving report and the nurse receiving.
- Delay in treatment
- Patient sent to the med/surg unit low hemoglobin without report

Purpose of the Project

- To prevent treatment delays and optimize information received during hand-off report from ED nurses and the medical/surgical unit nurses
- Develop an effective process during patient transfer

Framework



Methodology

- DNP project guided by the Rosswurm & Larrabee framework.
- Problem identified at facility
- Conducted literature review
- Policy and procedure developed to address hand-off practice between ED and the med/surg unit
- A standardized hand-off tool developed to address safety concerns

Evaluation

- Formative input from team leaders of emergency department and medical/surgical units

Acknowledgements

- Team Leader: Dr. Cyndi Cortes
- Team Member” Hamoy Chang, MSN