The Impact of a Standardized Patient Handoff Tool on Student Communication in the Clinical Setting
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Background
- 80% of medical errors involve ineffective communication when patients are transferred between healthcare workers (Nether, 2009).
- Lack of standardization contributes to miscommunication and leads to errors of omission during patient handoff (Ong & Coiera, 2011).
- Use of standardized communication techniques have been shown to improve transfer of important patient information during handoff (Pothier, Monteiro, Mookiar, & Shaw, 2005).
- Lack of published evidence regarding nursing students and use of standardized handoff tool.

Purpose and Aims
To teach students effective communication skills during patient handoff through the use of a standardized tool:
- Student education in use of the modified IPASStheBATON standardized handoff communication tool.
- Evaluation of student transfer of critical patient information during handoff pre/post use of the standardized tool.

Methods and Intervention
- Two recordings of handoff report.
- Pre/Post test Quality Improvement Pilot Study.
- Recording #1 made during first two weeks of clinical before instruction with tool.
- Instructed to “record the information about your patient that you consider important”.
- Education about evidence and use of tool.
- Practice in use of tool.
- Recording #2 made during last two weeks of clinical rotation after education and practice with tool.

Participants
Accelerated Baccalaureate of Nursing Science (ABSN) students:
- Junior level students.
- Second degree students.
- Enrolled in acute care clinical rotation.
- 24 students recruited.
- 5 students consented.
- 4 students completed both recordings.

Tool
I PASS the BATON
- Public domain mnemonic
- Team Strategy and Tools to Enhance Performance and Patient Safety (Team STEPPS).
- Aimed at successful patient safety outcomes through improving communication and teamwork.
- Modified version used.
- 29 critical data points identified.

Data Collection
- Student reported on the patient they had cared for in clinical that week.
- Private conference room at College of Nursing.
- Control of Bias:
  - Student alone during recording to eliminate faculty or peer prompting.
  - Transcription of recordings.

Analysis
- Faculty developed rubric.
- Critical patient data points identical to handoff tool.
- Percentage measurement of information transfer evaluated pre and post use of the tool.

Results
- Recording #1 Pre Implementation of the tool:
  - 19% – 26% of data was transferred.
- Recording #2 Post Implementation of the tool:
  - 90% to 97% of data was transferred.

Limitations
- Small number of participants.
- Scheduling appointment times for recordings.
- Interpretation of 3 areas of data transfer.
- Recent changes.
- Response to treatment.
- What is the plan.

Conclusion and Discussion
- The goal of the handoff is to provide timely, accurate information about a patient’s care plan, treatment, current condition and any recent or anticipated changes.
- Nurse educators must prepare nursing students to have effective communication skills and accurate transfer of information to ensure continuity of patient care and safety.
- The findings of this pilot project demonstrated an increased percentage of patient information included with use of the tool.
- Continued research with larger numbers of nursing students is needed to show a link between the use of a standardized handoff tool and an improvement in student communication during handoff report.

References
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