Title:
Implementation of a Standardized Handoff during Transition of Care from the ED to the ICU

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Session Title:
Rising Stars of Research and Scholarship Invited Student Posters
Slot (superslotted):
RSG STR: Saturday, 18 March 2017: 7:30 AM-8:00 AM
Slot (superslotted):
RSG STR: Saturday, 18 March 2017: 9:45 AM-10:15 AM
Slot (superslotted):
RSG STR: Saturday, 18 March 2017: 1:30 PM-2:00 PM
Slot (superslotted):
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Keywords:
Emergency Department (ED), Intensive Care Unit (ICU) and Nursing Handoff

References:


Abstract Summary:
Handoff from emergency departments (ED) to intensive care units (ICU) presents nursing challenges due to patients’ grave conditions. Vital patient information may be omitted; stabilization of critically-ill patients may not occur. This evidence-based practice project implemented a standardized handoff from ED to ICU to improve communication and patient safety.

Learning Activity:
Abstract Text:

ABSTRACT

Patient safety and communication are crucial to the nursing handoff. Emergency department (ED) patients transferring to the intensive care unit (ICU) have life-threatening impairments. Stabilization of critically ill patients may not occur until after the handoff has occurred. Often, vital patient information may be omitted. EDs can be chaotic with numerous distractions that adversely affect the nursing handoff. The Institute of Medicine published two groundbreaking patient safety publications highlighting handoffs: *To Err is Human: Building a Safer Health System* (1999) and *Crossing the Quality Chasm* (2001). In 2006, the Joint Commission recognized handoffs by adding transition of care with the National Patient Safety Goal 2E (2006). The purpose of this evidence-based practice project is to implement a standardized handoff from the ED to the ICU to improve nursing communication and patient safety. The review of literature supported implementation of a standardized handoff. Melnyk and Fineout-Overholt's (2001) hierarchy of evidence ranked 15 separate sources: Two level III, one level IV, five level V, four level VI, and three level VII. The Johns Hopkins Nursing Evidence-Based Practice Model and Guidelines revealed six high quality sources and nine good quality sources. The Stetler Model provided guidance and direction during implementation of this project. Rogers’ Diffusion of Innovation was used to assess nurses’ willingness to adopt the handoff intervention. A 205-bed, non-profit, Midwestern hospital was the setting for this intervention. The ED and ICU managers, the nurse educator, and the Chief Nursing Officer all understood and supported the proposal. Education of the standardized handoff occurred over a one week period during staff meetings and change of shift in the ED and ICU. A PowerPoint® presentation was given and questions from nurses in both the ICU and ED were answered. At that time, a demographics form was completed as well as a pre-intervention questionnaire asking nurses about the current handoff practice. This handoff implementation continued for eight weeks. At the end of the implementation phase, ED and ICU nurses will complete a post-implementation questionnaire. Communication and patient safety will be compared from the two months prior to implementation of the standardized handoff to the two months during implementation using a paired t test. Descriptive statistics will compare pre-intervention and post-intervention questionnaires regarding nursing attitudes and communication on a Likert Scale along with completeness of the handoff items. The time patients spend in the ED waiting for an ICU bed prior to arrival to ICU and MIDAS risk reports will be audited and
compared to the two months prior to implementation of a standardized handoff. It is anticipated that implementation of a standardized handoff will improve both nursing communication and patient safety.