

Title:

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

Melinda Abbring, BSN

College of Nursing and Health Professions, Valparaiso University, Valparaiso, IN, USA

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):

RSG STR: Saturday, 18 March 2017: 3:45 PM-4:15 PM

Keywords:

Emergency Department (ED), Intensive Care Unit (ICU) and Nursing Handoff

References:

Klim, S., Kelly, A., Kerr, D., Wood, S., & McCann, T. (2013). Developing a framework for nursing handover in the emergency department: An individual and systematic approach. *Journal of Clinical Nursing, 22*, 2233-2243.

Toccafondi, G., Albolino, S., Tartaglia, R., Guidi, S., Molisso, A., Venneri, F., ...Barach, P. (2012). The collaborative communication model for patient handover at the interface between high-acuity and low-acuity care. *British Medical Journal Quality Safety, 21*,58-66.

Zou, X., & Zhang, Y. (2016). Rates of nursing errors and handoffs-related errors in a medical unit following implementation of a standardized nursing handoff form. *Journal of Nursing Care Quality, 31*(1), 61-67.

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:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
<p>The learner will be able to name the six steps involved in the implementation of a standardized handoff from ED to ICU found in the review of literature and discuss their importance as related to nursing communication and patient safety.</p>	<p>Laminated placards containing the Review of Literature/Implementation of a Standardized Handoff will be on display for educational purposes. Large placards were placed in the break room and at the nurses' station in ED and ICU during the implementation phase. Small placards were found attached to each computer used by the nurses during handoff.</p>
<p>The learner will be able to name at least one of the three institutions that published findings highlighting the importance of nursing handoff as a safety measure. Publications from these three institutions preceded the implementation of this evidence-based practice project regarding ED to ICU handoff.</p>	<p>The poster will have a Background Section highlighting the Institute of Medicine's two ground breaking publications: <i>To Err is Human: Building a Safer Health System</i> (1999) and <i>Crossing the Quality Chasm</i> (2001), the Joint Commission's National Patient Safety Goal 2E (2006), and St. Mary Medical Center's Culture of Patient Safety Survey (2015).</p>

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* (2004). In 2006, the Joint Commission recognized handoffs by adding transition of care with the National Patient Safety Goal 2E (2014). 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.