ABSTRACT
This study explores reducing patient safety events, improving patient and employee satisfaction, and increasing collaboration between units through the implementation of a standardized handoff tool.

BACKGROUND
The Joint Commission (2012) estimates that approximately 9% in nursing; 5% in OB, and 46% within other services such as anesthesia, emergency medicine and radiology, were directly related to miscommunications among healthcare providers and healthcare consumers. The CRICO group identified 7,149 cases in which communication failures contributed to patient harm with “communication challenge” as the sentinel attribute. This results in an estimated 644 medical error cases in nursing-related services alone.

This community hospital attempted to implement a standardized hand-off tool. However, due to self-reported issues by staff such as complexity, non-customization of the tool, and inconsistency; the process caused increase anxiety and dissatisfaction among staff and patients. Patient and staff satisfaction plays an integral role in patient outcomes and quality of patient care.

PURPOSE
The purpose of this project was to create a unique hand-off tool between two units (Peds ER & PICU) to improve communication and transition of care between these identified units.

METHOD
The community hospital is a 464 bed acute care level I trauma facility located in South Florida that consists of an adult hospital and a children’s hospital. The children’s hospital consists of two pediatric floors, a pediatric oncology floor, a pediatric intensive care unit, a pediatric inpatient rehab unit and a pediatric emergency room. On average, the children’s hospital alone admits 5,000 patients a year.

Root cause analysis identified that improper hand-off between two units created a substantial patient safety event despite using the standard SBAR:

a. Missed patient information
b. Missed orders
c. Communication breakdown between units
d. Patient safety affected
e. Employee inter-unit trust/relationships affected

At the time of this publication, the hand-off tool from Peds ER to PICU has been piloted in this community hospital.

RESULTS
From this, a unit specific hand-off tool was created for what can be known as one of the first transitions in the children’s hospital, the transition between the pediatric emergency room to a higher level of care, the pediatric intensive care unit or PICU. Multiple surveys and meetings with the community hospital’s leaderships and stakeholders (key administrators, quality improvement team, physicians, nurses, allied health services, etc.) was required to create the Specialty Area hand-off tool from Peds ER to PICU.

FIGURE: PEDIATRIC SBAR TOOL

TABLE: SBAR DATA

REFERENCE
Eberhardt, S. (2014). Improve handoff communication with SBAR. Nursing, 44(11), 17-20. DOI: 10.1097/01.NURSE.0000454965.49138.79