

Standardized Shift Report Tool for RNs in Intensive Care Areas

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Introduction

Conducting a patient handoff from one Registered Nurse to another is arguably one of the most important aspects of nursing practice and patient safety. Poor communication leads to inadequate patient handoffs and increases chances for errors. Standardization of communication during these handoffs is suggested to improve patient safety outcomes, however no such nationally recognized tool exists to facilitate standardized handoffs in our current patient care areas.

PICO Question

Population: Staff Registered nurses at the Penn State Hershey Children's Hospital, specifically the Pediatric Intensive/Intermediate Care Units.

Intervention: Implementation of unit-based standardized handoff communication/report sheet.

Comparison: The lack of any standardized report tool (RN's own preference) vs. a developed unit-based standardized tool

Outcome: Better communication between nurse to nurse at handoff results in safer nursing practice.

Question: Will the registered nurses of the PICU/PIMCU experience better communication and discussion of patient information, thus improving patient care, when utilizing the standardized shift report when compared to previous methods?

Methods

A literature search was conducted using Google Scholar, OVID, EbscoHost, and PubMed databases.

Keywords: *nursing standardized shift report; nursing patient handoff tools*

Inclusion Criteria: Articles within 10 years, inpatient hospitals, nurse to nurse handoff

Tool Development: The unit-based standardized shift report was developed with the use of: previous individualized nurse handoff report tools, the report guideline in the PICU/PIMCU handbook, and thorough discussion and feedback amongst our unit on important topics vital to be communicated at handoff. A handoff tool was distributed for voluntary participation on the unit. In order to evaluate this tool, a survey was distributed through email and comment sheets were placed on the unit. Additionally, verbal feedback was provided at the conclusion of the study.

Results

Articles	Methods	Results
Zinn C. (1995)	The study is based on 1,4000 admission records in 28 public and private hospitals in New South Wales and South Australia. The data were extrapolated to achieve a national figure.	In Australia, 11% of 30,000 preventable adverse events that lead to permanent disability were due to communication failure at patient handoff, compared to 6% attributed to the inadequacy of the nurse's skill level.
Salas, E., Almeida, S.A., Salisbury, M., et al. (2009)	A systematic review that focused on the critical success factors of team training in health care, specifically communication.	The Department of Veterans Affairs attributed communication failure amongst health care workers as the primary cause in 75% of adverse events or "close calls."
The Joint Commission Sentinel Event Data Unit (2013)	The Joint Commission includes the review of organizations' activities in response to sentinel events in its accreditation process, including all full accreditation surveys and random unannounced surveys.	A report from the Joint Commission reported that 70% of all sentinel events were the results of communication error.
Riesenberg, L.A., (2010)	A systematic review that focused on nursing handoffs in the United States.	Studies show that strategies for effective handoff include standardizing the process. An example includes using a tool to ensure that essential information is consistently included. It also mentions that including staff in the development of guidelines, tools policies and procedures increase effectiveness for handoff.

Population:

- It is unknown how many nurses out of 100 nurses employed by the units utilized the shift report.
- 1 nurse out of 100 nurses completed the written survey
- 10 nurses out of 100 provided verbal feedback
- 17 out of 100 nurses completed the online survey

Results of Online Survey:

- 60% of the nurses found the shift report somewhat helpful when receiving report while 40% found it very helpful.
- 55% of the nurses did not feel that the shift report was more time efficient; 45% thought the report allowed more time to ask questions.
- 65% of nurses felt they had a better understanding of their patient after utilizing the report sheet; 35% did not.
- 65% of nurses said they were more than likely to utilize the standardized report sheet; 35% said they definitely will use it.

Discussion

Weaknesses of our study:

- Small percentage of our population utilized our handoff report and survey
- Large percentage of staff said that the report sheet did not save time during handoff
- Inconsistency of utilization of the report sheet created some discordance during report.
- The question: "Does this standardized report sheet serve as a better communication tool at handoff?" was never addressed.

Positive Feedback of Our Survey:

- Continuity of communication in an organized manner
- Comprehension, easy to follow/flows well,
- Reminded the staff of items they may have forgotten in report.

Future Actions and Studies:

- Implementation of tool across our entire target population with support by leadership and management.
- Address the question in a survey format: "Does the standardized report sheet serve as a better communication tool among nurses at hand-off?"
- Develop a way to systematically measure if the tool does in fact improve the communication of patient information.
- Lastly, the final tool should be developed by a committee of all levels of nursing experience.

Conclusions

Our tool has already been implemented on a voluntary individual basis on our units as part of our data collection process. The data has proven that overall RNs support the use of this tool to continue to help implement safer practice; however, a committee will need to be formed to finalize the tool before formal implementation.

References

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