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Introduction of the Problem

Surgical patients are a vulnerable population in healthcare. The Joint Commission estimates that 80 percent of medical errors are related to communication breakdown during the patient handoff (Robins & Dai, 2015). A standardized patient handoff tool can be beneficial to patient safety and also increase satisfaction between anesthesia providers and post anesthesia care unit (PACU) nurses with the transfer of patient care. With this clinical focus, The Joint Commission recommends a national goal to improve patient safety through the enhancement of patient handoff (Robins & Dai, 2015).

Literature Review

Many common themes surfaced during the review of the literature on patient handoffs. One of those themes is the current patient handoff process. Basic patient health information was not being communicated in handoffs (Smith et al., 2008). Only 40 percent of handoffs included preoperative status and 55 percent included essential information, such as patient allergies (Manser and Foster, 2011). The second common theme noted in the literature review is the effect that communication styles have on patient handoffs. The lack of standardization leads to the possibility for information loss by relying solely on the abilities of the provider to clearly communicate the patient handoff (Robins & Dai, 2015). Another common theme was which pertinent information to include in the handoff. This is where the development of a standardized handoff becomes troublesome. The regulating bodies have difficulty developing a nationwide standard form because not all institutions need the same information during handoff. Boat and Spaeth (2013) recommended all members of the direct patient care team be involved in

developing a list of essential components specific to their workplace. The delivery type of the handoff is the final common theme noted in the literature. Handoff checklists with verbal communication had more information transferred, less critical data lost, and the greatest information recall in simulations compared to verbal patient handoff without a checklist (Gardiner, Marshall, and Gillespie, 2015). Gardiner et al. (2015) found that through seven studies measuring information transfer, 25 percent more critical information was passed along during a standardized handoff protocol. The duration of the handoff was not significantly increased based on the use of a structured handoff protocol versus an unstructured verbal handoff (Gardner et al., 2015).

Project Methods

The setting of this project was the anesthesia department and PACU at a local Midwest hospital. The stakeholders in this study included the anesthesia department, PACU nurses, surgical patients, families, and hospital system. Authorization to use the PACU was granted by the chief Certified Registered Nurse Anesthetists (CRNA). The Institutional Review Board of Southern Illinois University Edwardsville deemed the protocol exempt from further review (Appendix C).

Evaluations

Pre-implementation surveys were distributed to staff members prior to education about patient handoff by the author. Staff were educated by the author about the use of the handoff tool by presentation of a PowerPoint that introduced and explained the handoff tool and current literature pertaining to patient handoff. Staff were observed during the first day of implementation to make sure the tool was used effectively and questions were answered. The author followed up with the chief CRNA every week during implementation to make sure

questions were answered and the tool was being used consistently and accurately. No additional clarification was needed regarding the use of the handoff tool. The handoff tool was used in the way that the author intended. After implementation of the handoff tool for one month, post-implementation surveys were distributed to evaluate patient handoff after using the standardized tool by the author.

Impact on Practice

Prior to implementation of the standardized handoff tool, sixty-four percent of the anesthesia providers and PACU nurses felt positively that information is commonly missing from the handoff report. The highest number of responses were neutral when asked about satisfaction with clarity and efficiency in the handoff and the overall satisfaction with the current patient handoff. After implementation of the standardized handoff tool, the results demonstrated a positive response. All of the anesthesia providers and PACU nurses agreed or strongly agreed that the handoff was consistent and complete. Almost all of the anesthesia providers and PACU nurses strongly agreed that they are able to ask questions if needed to gain more information on the patient. The majority of participants in the survey also strongly agreed that they are satisfied overall with the handoff after using the standardized tool.

Conclusions

This project has several limitations. These limitations include the small sample size, specific setting, and inability to generalize the findings. The project and handoff protocol will be easily sustainable. After the one-month implementation period, the protocol can be adjusted to include or remove certain elements that the anesthesia providers and PACU nurses deem necessary. The project evaluated the staff satisfaction with the consistency, clarity, and information transferred through the use of a standardized patient handoff tool. This project

confirmed that the use of a standardized handoff tool can increase overall satisfaction and perceived clarity and efficiency with patient handoff in the majority of anesthesia providers and PACU nurses at a local Midwest Hospital. All participants agreed that using the standardized handoff tool has made the patient handoff consistent and complete.

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