

Lessons Learned, 2006 #01 Strengthening Handoff Communication

The Case

Mrs. Jane Smith, a patient admitted to a medical-surgical unit, had an order to receive a routine chest x-ray in the Radiology department. A transporter came to the unit to take Mrs. Smith for her test. The nurse caring for Mrs. Smith informed the transporter that Mrs. Smith had a thoracic spine fracture and needed to remain flat and to not be log rolled when transferring between beds. Mrs. Smith's nurse also informed the transporter that Mrs. Smith was pretty sleepy because she had just received some pain medicine for her back pain.

When the transporter delivered Mrs. Smith to the Radiology Department, the staff asked him to place her in the holding area because they were behind schedule. The transporter obliged and left to take another patient back to their hospital room. After several minutes, the radiology staff brought Mrs. Smith into the room for her x-ray. To maximize the quality of their study, they placed Mrs. Smith in an upright position. After the x-ray was completed, another transporter was asked to take her back to her room.

Mrs. Smith arrived back to the medical-surgical unit and was placed in her room. When Mrs. Smith's nurse came in to give her scheduled medications she was shocked to see her sitting in an upright position. She immediately lowered the head of the bed and called the patient's physician. A neurologic exam revealed that Mrs. Smith could no longer move her legs.

Commentary

Although the case described above is fictional, it is representative of what can occur when handoff communication is inadequate.

- **Ineffective communication among team members is the most frequently identified root cause (underlying) cause of sentinel events, both here at VCUHS, as well as nationally.**
- Patient handoffs provide opportunity for error. In health care, there are numerous examples of handoffs:
 1. Transferring complete responsibility for a patient
 - Physician or medical staff service transfers
 - Nursing and physician reports between emergency departments, surgical to postoperative care, different inpatient settings, different hospitals, nursing homes, and home health.
 - Nursing shift change
 2. Temporary transfer of responsibility
 - Physician transferring 'on call' responsibility (e.g., "sign-out")
 - Temporary acceptance of responsibility for patients of a nurse who leaves the floor
 - Temporary transfer of responsibility to diagnostic or procedural staff

Action Points

1. Standardize handoff reports. A consistent format increases the amount of information you accurately record and recall, and improves your ability to provide safe patient care. A 2006 JCAHO National Patient Safety Goal requires standardized handoff communication. Beginning in February 2006 at VCUHS:

- A. For temporary transfers (such as those to a procedural/diagnostic area), nurses at VCUHS should utilize the new "Handoff Communication Form" to standardize communication:
 - "Handoff Communication Form" is used when TEMPORARILY transferring care, such as from a nursing unit to Radiology, Cath Lab or Peripheral Vascular Lab.
 - Personnel transporting and receiving the patient should review the information and use it to provide care during transport and at the destination.
 - Procedural and diagnostic area staff should complete the bottom section of page.
 - This form does NOT replace verbal communication. The sending nurse should always include a phone number; so receiving personnel can ask and respond to any questions.
 - B. Complete the "Nursing Transfer Note" and give a verbal report to the receiving nurse whenever transferring a patient from one inpatient unit to another.
2. Following are additional strategies, recommended by the Institute of Medicine report *Crossing the Quality Chasm*, to make sure handoff communication occurs effectively and efficiently:
- A. Avoid vague, unclear, or potentially confusing terms ("he's doing fine," or "she's lethargic").
 - B. Limit interruptions and allocate sufficient time to this important task.
 - C. Use repeat back and clarifying questions to make sure there is common understanding.
 - D. Encourage interactive questioning to allow for better absorption.
 - E. Keep the report patient centered and avoid irrelevant details.