Background

Gaps in communication during handoff has been an ongoing problem in health care and is a significant factor to adverse events such as falls, delays in treatment and medication errors. Consequently the Joint commission designated standardized handoff communication as one of its national patient safety goals in 2006. Since that time, the Joint Commission has released several reports on the importance of standardizing handoff communication. A handoff tool such as SBAR, or Situation Background Assessment and Recommendation, enables caregivers to communicate patient information in a concise, clear, and consistent manner. In doing so, important patient information is not lost in the transition of care thereby reducing potential for errors. Evidence also suggest that moving shift report from the nurses station to the bedside helps to reduce the risk of errors through verification of IV medication, assessment of wounds and visualization of the patient’s general appearance. Ultimately the use of a standardized communication tool in combination with bedside report will help to increase nurse accountability and overall patient safety.

Aim Statement

The goal of this quality improvement project is to increase the percentage of observed safety checks by greater than 75% during bedside handoff by mid-March.

Outcomes

Nursing Compliance with Safety Checks

In the 12 weeks following the initial education and implementation, audits revealed 89% RN compliance with safety checks during bedside handoff. This is a 585% increase from the Pre-Data compliance of 13%.

Follow up audits of handoff have continued throughout the post initiation period. Real time education and coaching is provided during audits to foster the process.

Conclusions and Lessons Learned

Patient safety is improved through standardized bedside handoff and incorporating dual RN safety checks. Incorporating dual safety checks promotes RN accountability and allows for confirmation of patient assessment eliminating any questionable change in patient status. Sustained improvement to handoff communication should show a positive reduction in adverse events.

Since the initiation of this project, the Surgical ICU can report zero patient falls related to the absence of active bed and chair alarms in use. Positive results and reinforcement is shared with all staff members at daily shift huddles and monthly staff meetings to promote sustainability.

REFERENCES