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Improving Hand Off Communication to Enhance Patient Outcomes and Staff Satisfaction

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Author Note

This paper was prepared for N653: Internship: Clinical Nurse Leader, taught by Professor Gallo

Clinical Leadership Theme

The current project will focus on the clinical nurse leader (CNL) curriculum component within two areas: *Care Environment Management* and *Clinical Outcomes Management.* To perform the CNL position, there will be the use of team resources. The CNL will serve as a leader on the interdisciplinary team, and use data to change the practice and improve the outcomes of the hand offs. This will achieve optimal client outcomes. Additional information about the CNL is important to know in order to understand how important their role is in the medical field. A CNL is a 1) facilitator of direct care, 2) works with medical staff who care for their patients, 3) provides guidance, support, and assessment of patients who require complex needs in healthcare, discharge, and rehabilitation, 4) communicates and be involved with medical and interdisciplinary teams, 5) introduces evidence-based practice to their staff, and 6) promote involvement of staff with various levels of decision making (Monaghan, 2011).

As the CNL, it will be vital to lead the intervention process of the hand offs between the client advocates (CAs) and the nurses. The intervention process (see Appendix B Process Mapping) includes the client advocate coming to the nurse with information regarding the client. The client advocate is to record pertinent information regarding the client in the hand off form. The client advocate will provide the information to the nurse in a quiet and peaceful environment in about two minutes. The nurse may ask the client advocate for additional information that may help with the assessment. The client advocate and nurse need to remember the main goal is to provide safe and quality care.

Nursing Relevance

The hand off that occurs between two medical staff or between two individuals caring for the client is a time honored nursing ritual that can have significant impact on several outcomes

not only for patients, but also for staff. The Joint Commission (2006) has called for standardization of this process to improve patient safety and continuity of care. The change of shift hand off, if done properly, can open the door to multiple avenues resulting in improved quality of patient care, patient safety, relationships between nurses, and patients and their families. The quest to create the perfect hand off (see Appendix G) is a complex and difficult task, but one that has the potential to produce great rewards for patients, nurses, and medical care facilities.

Statement of the Problem

Improving hand off communication to enhance patient outcomes and staff satisfaction will be accomplished by identifying trends and failed processes with the goal to reduce communication errors. There is the following important information collected through research that provides the weaknesses or errors that may occur during hand offs.

National Data on Hand-Over Communication Weaknesses or Errors

- Poor communication is the top-contributing factor to medical error with inadequate handoffs playing a major role
- Poor teamwork and communication between medical and nonmedical staff causes patient safety incidents
- Ineffective handoffs is a contributing factor causing gaps in patient care
- There is incomplete or missing information during handoffs
- Handoffs can have, but should not have, variability in quality, lack of structure, and variances
- Handoffs is a technique used to help with communication for the situation, background, assessment, and recommendation (SBAR) briefing model (Friesen,

White, & Byers, 2008).

The subpopulation consists of females who want to have pregnancy and STD testing performed. The clients live in the Napa Valley community and county of Napa. Individuals from the surrounding counties of Vallejo and Solano also come to the clinic. The clients are generally Hispanic females, married (39.6%) or unmarried (40.8%) (Races in Napa, California (CA) Detailed Stats: Ancestries, Foreign-born residents, place of birth, 2014). The majority of clients range in age from 18-25. This project is vital to client and nurse safety and satisfaction because it will reduce the amount of unnecessary time spent with the client during assessment and eliminate the need for the patient to schedule follow up appointments. There will be a decrease of returning clients because the initial exam will be performed more efficiently, thus time will not run out necessitating the need to schedule additional appointments. Clients will feel that their needs and questions have been met and the nurses will feel better in the knowledge that they provided quality care. Having happy staff and clients will always be best for the clinic (Pressganey.com, 2010). There will be a cost benefit because the client will not need to return for other appointments, which would be necessary due to unanswered medical questions. Plus, more clients will be seen during the workday.

The sustainability plan for the CNL project includes five factors. The five factors in the quality improvement project are: 1) Modification: the communication during hand offs is patient centered, efficient, and effective and the hand off form has been changed to include pertinent questions that need to be answered by medical staff and client advocates. 2) Having a champion: the clinic wants to move forward with quality care and having a CNL involved with this project will help ensure that possibility. 3) Fit with the organization's mission/procedures: the mission

is to provide safe and quality care for the client. This will be accomplished by improving communication during hand offs. 4) Perceived benefits of the staff/clients: benefits for staff will increase because individuals will help each other. Clients will benefit because quality of care will increase which increases their satisfaction. 5) Support from stakeholders: all staff is supportive of this project because there are more positive outcomes than negatives.

Project Overview

The global aim statement includes the following: The professional staff at the clinic aim to improve communication during hand offs in the crisis pregnancy clinic. The process begins with having patients fill out a survey on their experiences at the clinic indicating whether there were any issues during the appointment. The surveys will be reviewed weekly and kept track through the computer program, Ekyros. The process ends with an improvement in communication during hand offs by seeing fewer returned patients, 100% compliance by staff to follow through with asking the correct questions of the patients, relaying pertinent information to the nurses, resulting in better patient survey results. This will be completed by August 6, 2015; however, there will be ongoing reviews. By working on the process, it is expected to yield better information exchanged between client advocates and nurses, less errors with information exchanged, and decrease in the amount of unnecessary time spent with the patient. Better information equals better patient care and outcome, documentation will be more precise, and decrease in the number of return appointments because of previous incomplete appointments. It is important to work on this now because: 1) patients are unnecessarily coming back again due to going over the allotted appointment time, 2) misinformation is being exchanged, 3) client advocates are deciding what information should be exchanged with the nurses, therefore, often nurses are not getting correct client history, 4) there is lack of trust and teamwork between staff

which is affecting moral and quality of patient care and safety, 5) there will be an improved hand off form made, and 6) a framework for addressing continuity of care issues have been identified by addressing this problem.

The specific aim statement for this project is the following: Improving hand off communication to enhance patient outcomes and staff satisfaction between the client advocates and nursing staff by 50%, with a goal date of August 6, 2015. This will increase patient safety and satisfaction. The contributing factors will be researched by using the cause and effect analysis method. The specific aim statement relates to the global aim statement because both have the same goal of improving communication during hand offs in order to have better patient outcomes and staff satisfaction. The long-term goal of the project will be to continue this process with monthly, quarterly, and yearly reviews. It will be important for the staff to remain flexible because changes may occur with the hand off form and training in order to obtain better client and staff satisfaction, along with improved client care and outcome.

Rationale

The global aim is to improve client outcomes at the clinic, but first the problem needed to be identified in the microsystem. After noticing a decline in the proper client information being transferred from client advocate (CA) to nurse during hand offs, it was established that this problem needed to be fixed. An example of misinformation being exchanged during hand off is illustrated in the following story. A client came in for STD and pregnancy testing. The client had mentioned to the client advocate that her current partner and previous partners had sexually and physically abused her. The client advocate decided to keep this information to herself and not verbally exchange it with the nurse during the hand off. The nurse only found out about the abuse when entering the exam room, the nurse noticed the client had a black eye and bruises on

her arms. After the assessment was complete and the client was filling out some more paperwork, the nurse had a brief meeting with the client advocate to review what just occurred and asked her why some information was not disclosed during the hand off. The client advocate mentioned that she thought it was not necessary. The nurse educated her that anything like that should be mentioned to the medical staff. The result of this appointment was the client advocate and nurse came to an agreement to have all information about the client disclosed to the nurse because it was important for both CA and nurse to provide the best care possible to the client and it was important to work together as a team.

Upon obtaining organizational consent and discussing the goals of the process for the communication problems with hand offs project with staff, a process map (see Appendix B) was developed. A FMEA (failure mode and effect analysis) was performed and problems relative to hand offs were identified. After reviewing literature related to this process improvement project a plan was implemented. The CAs and nurses were brought together to figure out what was wrong, how the hand offs occurred, and what to do to fix the problem. After the information was collected, the Clinical Director and this nurse met and discussed the next step in handling this situation. A meeting was set up with the CAs and nurses to discuss the situation and make them aware that a potential solution will be implemented to help solve the problem. Research was being explored to help solve the situation. The plan included staff meetings prior to client's arrival, having quality hand-offs, and review of client's visits afterwards, if time allows, or at the end of the shift. A Plan-Do-Study-Act (PDSA) was performed to evaluate the effectiveness of the communication problems with hand offs improvement project.

A FMEA was conducted to see what was currently taking place during hand offs and identified the cause as poor communication. The fishbone diagram (Appendix A) indicates how

barriers such as poor teaching of the process of hand offs can lead to poor communication during hand offs. The process map (Appendix B) indicates areas of concern in the workflow process that is causing the communication problems.

The SWOT analysis (Appendix C) identified threats for the project that will require attention. The threats are: having donated equipment, as the clinic is nonprofit; improve compliance with training, and to seek electronic health record (EHR) education to improve the documentation process. This project is of interest to clients, healthcare professionals, and the clinic as an aspect of patient safety, satisfaction, and continuity of care.

There are strengths and weaknesses for the project. Two strengths are: the staff is small and close knit and secondly, there is a feeling in the atmosphere of support and care. Two weaknesses are: the clinic staff being resistant to training and communication inconsistencies. Lack of funding, donations, and donated equipment causes many problems at the clinic. The computers are older and unreliable. Documentation takes longer. The biggest weakness is the staff being resistant to training. Unfortunately, most of the staff are busy working fulltime at other hospitals and are comfortable with their hospital's computer programs and are reluctant to learn the program at the clinic. However, to help mitigate this weakness, time has been set-aside with each employee for training.

There has been positive reinforcement with each employee and review of documentation has been helpful. Progress is being made. Open communication is a key component for better documentation. Donated equipment is another major issue. One possible solution is more carefully using the funds for specific items that are required in the exam room and only purchase when necessary and in bulk. It will be important to make sure that the equipment is state of the art. The importance of having money from fundraisers and donations allotted for medical

supplies will be stressed. The grant writer from the clinic will be asked to broaden the search for funds and grants.

The CNL competency, Quality Improvement and Safety, is related to the opportunity of staff improving communication in the SWOT analysis. There will be continued assessment and promotion of the importance of staff having proper written documentation and effective verbal communication with their clients and CAs in order to have quality of care for the clients' outcomes.

Cost is an important outcome to evaluate and can be measured in several ways. The cost of the client advocates (CA) is zero because they are volunteers, the Director of CA is $15/hour, and the nurse is $28/hour. Financial considerations related to breaches in patient identity and delays of care are sanctions from the Joint Commission in the form of fines or loss of accreditation. There are costs associated with care delay because of ineffective communication during hand offs. Overtime worked by the nurses will add salary expense. It can be hypothesized that the clinic could save an estimated $3,360 ($10,080 for 3 months see Appendix E) in overtime over one month pay-period, by decreasing overtime.

A client who has an unfavourable experience at the clinic may deter other clients from seeking care at the clinic. There are three aims to improve the health care system: improving the experience of care, improving the health of the population, and decreasing the per capita costs of the health care. This is called the Triple Aim. A change in one aim can affect the other two (Berwick, Nolan, & Whittington, 2008). The cost for the client is zero. There are staff volunteers, which equals zero costs. The equipment is donated and the funding comes from donations, grants, and fundraisers. This project will not be expensive. The current hand off form will be updated and reviewed before implementation. Costs of implementing the new form

should be relatively low. A majority of the costs will be the printing of the paper materials. Refer to Appendixes E and F for costs. Adhering to national and organizational standards concerning client identification will help prevent and mitigate breaches in client information and delay of care. Client safety, quality of care, and better communication are the goals of the clinic. Using information from the Exit Survey (see Appendix H) will help the clinic improve their services for the health of the population in the community and experience of care.

Methodology

First, the problem was identified as a decline in proper client information being transferred from client advocate (CA) to nurse. The CAs and nurses were brought together to figure out what was wrong, how were the hand offs occurring, and what to do to fix them. After the information was collected, the Clinical Director and this nurse met and discussed what would be the next step in handling this situation. A meeting was set up with the CAs and nurses to discuss the situation and make them aware that there is a process that will be implemented to help solve the problem and research was being conducted to help solve the situation. The method of instruction will be: initial group instruction, team learning simulation, 1:1 instruction, and demonstration and return demonstration by learner. The quantifiable data collected will be from the client filling in a questionnaire (see Appendix H) after each appointment that will include questions such as 1) How was this appointment?, 2) Were there any problems?, 3) How satisfied were they?, and 4) Did they have any suggestions for improvement? If the client is returning because of a previous appointment running out of time or needed to return because of misinformation, then the receptionist will have this information inputted into the Ekyros program. The data collected to see if the project is effective will be from the questionnaire that is reviewed weekly and kept track of through Ekyros. There will be numbers placed by the

questions and these numbers should decrease by 1 each time there is a review. The Likert Scale was used with numbers ranging from 0 to 4. The desired goal will be reached when there is a 0 inputted after each question and there are no extended or unnecessary appointments. There will be forms in Spanish because the population is mainly Hispanic. To ensure quality of care, this project will continue with debriefings and bi-annual reviews of the process.

Data Source/Literature Review

The problem was a decline in the proper client information that was being transferred from client advocate (CA) to nurse. PICO stands for patient, intervention, comparison, and outcome. It is used to help begin the planning process in research (Using PICO to help define the problem, n.d.). The PICO statement used to support the project is as follows: P-females ranging in age from 15-25 who are mainly Hispanic, I-a program used to train staff, both individually and in groups, C-observations of interactions during appointments, and O-educate the client advocates and nurses in how to communicate more effectively and efficiently during hand offs. Additionally, there are two separate clinical questions using a PICO format: "Would clients in the clinic benefit from improved nursing hand off skills as compared to the current process by exhibiting higher satisfaction scores for nurse communication and fewer safety errors?" "Would nurses in the clinic benefit from improved nursing hand off skills as compared to the current process by exhibiting less safety errors and decreased staff cost for overtime?"

Research using *Google, CINHAL,* and *Safari* included the words *communication errors with handoff, incomplete hand offs, improving, documentation, problems, nursing, communication, hand offs,* and *communication problems.* The years for the research were between 2008 and 2014. Newer research will help provide more accurate and up to date information. *Wikipedia* and other sites like this one are not used because they are less reliable.

The initial search located many articles regarding hand offs. It was overwhelming. To narrow the search, the search became more specific and the span of years was decreased. There was a lot of information regarding ineffective and inefficient hand offs. For this project, it was important to research and find information in the article(s) that focused on clinics. Time and patience were also valid skills to have during the research process.

There is data that shows patient dissatisfaction is strongly linked to communication problems. At the clinic there is often a lack of communication during hand offs resulting in poor patient care. Hand offs occur at various routine stages during the client experience. Before continuing, it is best to understand what a hand off is. A hand off is when the care and information of a client is transferred from one reliable person to another. At this clinic, the hand off occurs between the Client Advocate, who is a non-medical staff member, and the nurse, who is medical staff. The purpose of the hand off is to communicate pertinent client information in order to provide safe and continuous care. Understanding the importance of the hand off is vitally important. The Institute of Medicine (IOM) reported an extensive number of unfortunate and preventable medical errors in 2001. As a result of this, national attention was placed on improving the quality of care by improving communication between all involved parties. For more than 15 years, the Joint Commission, formerly known as Joint Commission for Accreditation of Healthcare Organizations (JCAHO), has gathered data and evaluated medical errors looking for the causes. There were over 4800 sentinel events analyzed. It was found that communication was a contributing factor in most of the medical errors.

The Joint Commission looked at the reviews of the 2006 Sentinel Event Advisory Group and implemented the National Patient Safety Goals. In 2011, a newer version was released. There were two goals established at that time. First, improve communication effectiveness with

caregivers. Second, have timely, accurate, clear, and understandable communications. These two newly established goals have the expectations of reducing error, improving patient safety, and increasing patient satisfaction. Additionally, the Joint Commission developed the Targeted Solutions Tool (TST) for hand off communications. As a result, there was an average of over 50% reduction in hand off errors by using a combination of the tool and goals (Joint Commission Center for Transforming Healthcare, 2014). Adoption of their methods benefits the medical facility. If not adopted, the patient is at risk for reduced quality of care and patient safety. The Agency for Healthcare Research and Quality (AHRQ) has found that communication problems are the most common cause of medical errors. This can occur either verbally or in writing. Communication failures can occur between staff and patient to staff. Unfortunately, this results in documentation that is poorly transferred both written or verbally (AHRQ, 2003).

Evidence to support the project

There were several articles researched that supported this project. However, six will be presented in this assignment. The site will be given and a brief description of each article follows.

Carrol, J., Williams, M., & Gallivan, T. (2012). The ins and outs of change of shift handoffs between nurses: A communication challenge. *Digital Commons @ILR*. Retrieved from http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1914&context=articles

The authors conducted a multi-method study of change of shift hand off between nurses that includes interviews, surveys, audio tapings and direct observation of hand offs, post hand off questionnaires, and archival coding of clinical records. The results indicated that there were

different expectations of what a hand off intake includes. The results indicated the need to have standardized forms.

Cohen, M. & Hilligoss, P.C. (n.d.). Handoffs in hospitals: a review of the literature on information exchange while transferring patient responsibility or control. Retrieved from http://deepblue.lib.umich.edu/bitstream/handle/2027.42/61522/Handoffs_in_Hospitals_D?sequence=1

The authors have gathered research specifically on hand offs with a specific aim to directly improve hand offs. The main area of focus will be on standardizing the form. The article, is divided into six sections: definition of hand off, functions of hand offs, challenges and difficulties of hand off, costs and benefits of standardization, possible protocols for standardizing hand offs, questions needing answers and methods of research, and then conclusions. It was found that there is little evidence showing impact of hand offs on patient safety.

Friesen, M.A., White, S., & Byers, J. (2008). Handoffs: Implications for nurses. *Patient Safety and Quality: An Evidence-Cased Handbook for Nurses.* Retrieved from www.ncbi.nlm.nih.gov/books/NBK2649/

Friesen, White, & Byers, Handoffs: Implications for nurses, (2008) asserts that essential information being transferred from one clinical staff to another is an essential part of communication in the healthcare setting. This type of transfer is called a hand off. The authors provided the definition of a hand off, information regarding ineffective hand offs, suggestions for quality improvements, examples of hand off expectations, and cited evidence that supported the importance of hand offs.

One such study the authors discussed used three methods of hand offs: 1) preprinted forms as well as verbal reporting, 2) note taking and verbal only reporting, and 3) verbal

reporting only. The success rates were as follows 96%-100% for preprinted forms, 31%-58% for notes, and 0%-26% for verbal only. This shows that information is lost when hand offs are verbal only. The authors researched using the following databases: CINAHL, Pre-CINAHL, EMBASE, PubMed, Ovid's Medline, and PsychInfo. This nurse searched for this article utilizing Google, *nursingworld.org*, Gleeson Library at University of San Francisco, Institute of Medicine, and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). The authors' purpose of writing this article was to provide information regarding the importance of having an efficient and effective hand off in order to provide the best, safest, and continuous high quality of care for the patient.

Halm, M. (2013). Nursing handoffs: Ensuring safe passage for patients. *AJCC American Journal of Critical Care.* Retrieved from http://littletonnhhospital.org/images/NursesPages/files/ Nursing%20Handoffs-Ensuring%20Safe%20Pasage%20for%20Patients.pdf

The author summarizes the findings in a table format that shows the reference, population, design and interventions, findings, and level of evidence. The research of articles was from 2007 to 2012. In the end, it was found that pre-printed standardized change-of-shift and interdepartmental hand offs have a positive impact on patient safety.

Handoff communication tool improves patient safety. (2012). Retrieved from http://confidenceconnected.com/blog/2012/10/25/handoff_communication_tool_improves_patient_safety/

The article describes an effective tool that measures the effectiveness of hand offs called Targeted Solutions Tool (TST). Many organizations that used this tool found positive outcomes, such as a reduction of 52.3% in hand offs that were problematic. Using the acronym SHARE to

address specific areas led to more successful hand offs. The acronym means: S=standardized critical content, H=hardware within your system, A=allow opportunities to ask questions, R=reinforce quality and measurement, and E=educate and coach. This helped minimize errors and costs while maintaining patient safety and increasing patient satisfaction.

Joint Commission Center for Transforming Healthcare. (2014). Retrieved from www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1

Joint Commission Center for Transforming Healthcare, (2014) asserts that hand off communications can be improved by using Targeted Solutions Tool (TST). The article provided the definition of a successful hand off and Targeted Solutions Tool. TST is a tool that organizations use to improve their communications during hand offs. It provides guidelines for appropriate hand offs, identifies areas of focus, and provides customized forms. There were studies cited that supported this evidence. One study had a reduction of readmissions by 50% and another cited study had the time reduced for a patient to go from the emergency room to the unit inside the hospital. There were ten hospitals involved in this research study and each one was able to identify their causes of failures and barriers to improvement. This article's purpose was to help provide a tool to organizations that would be used to decrease unsuccessful hand offs in order to provide better patient safety and reduce future healthcare visits. This nurse searched for this article utilizing Google, *nursingworld.org*, Gleeson Library at University of San Francisco, Institute of Medicine, and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).

The articles for this project support educating the client advocates and nurses on how to communicate more effectively and efficiently during hand offs. The articles' dates range from 2008-2014 and therefore the contents are considered relevant to this project. Each article cited

studies that supported the need for using effective and efficient hand offs to ensure quality patient care.

Timeline

The project began in May 2015 and concludes August 6, 2015. This is depicted in Appendix D, the Gantt chart. The Gantt chart reflects the timeline used during the hand offs improvement project. One challenge with this timeline included preparing for the clinical nurse leader (CNL) exam while completing this project and other assignments. Another challenge was ensuring information was being shared and received in a timely manner. For example, receiving feedback from the Clinical Advocate Director took more time than expected, which caused a delay in the completion of the project.

Expected Results

For the sustainability of this project, it is recommended to continue with monthly reviews. When three consecutive months show more than 90% compliance with communication during hand offs, then move to quarterly audits remembering to share results with staff. Finally, yearly reviews will occur and if results have improved then only yearly reviews will continue. However, if results have not improved, then re-orientation and monthly reviews will be reinstated until positive results occur. Any additional nursing and non-medical staff hired at the clinic will receive orientation on the communication during hand offs requirements. There will be continued staff huddles, open communication, and addressing of any problems as they arise. The project will become standardized at the clinic because improved communication during hand offs is one of the best processes that will provide quality and safe client care.

Summary Report

Hand off reports are the most common type of communication between nurses. Ineffective hand offs can have negative consequences on a client's health. There can be delay in care if the information received is not clear and concise. The wrong type of treatment and a risk for inadequate care may also occur. Effective and efficient communication during hand offs in the crisis pregnancy clinic not only increased client satisfaction and outcomes, but created an environment that promoted staff fulfillment as well.

This project is vital to client and nurse safety and satisfaction because it will reduce the amount of unnecessary time spent with the client during assessment and eliminate the need for the client to schedule follow up appointments. The purpose of this project is to examine the process, identify procedural flaw(s), and implement a plan to correct the flaw or flaws. Understanding the needs of the clinic's client population is beneficial as it pertains to the design of client care services aimed at improving quality of care. Improving client safety can be achieved by implementing a standardized and consistent approach to hand off communication. Studies and reviews show, as provided in this paper, that having proper communication occurring will result in positive patient outcomes and satisfaction.

The specific aim statement for this project was the following: Improving hand off communication to enhance patient outcomes and staff satisfaction between the client advocates and nursing staff 50% was achieved by the goal date of August 6, 2015. With 100% participation of staff members within a three month period and a reduction in unnecessary returned appointments due to improved communication during hand offs. A structured standardized hand off form was used for communication during hand offs using Situation, Background, Assessment, and Recommendation (SBAR).

The clinic is small with 2 exam rooms, 1 lab, 1 reception area, and an office for the client advocates with the Client Advocate Director, and another office for the Nurse Manager, Nurse Practitioner, and several other nurses. The majority of the clients are young Hispanic females ages 15-25. The non-profit clinic provides free services while still providing quality, medical care. Evaluation methods yielded both quantitative and qualitative results through chart audits and direct observations.

The new communication hand off form was placed in the clinic at the start date. In-services, one-to-one demonstrations, and answer and question sessions were implemented. Staff response was positive. After four weeks of using the new form and limiting time during hand offs, there were minor changes made which resulted in positive outcomes. Ongoing observations, guidance, encouragement, and debriefings occurred. Some staff struggled with the changes, but ultimately joined the team. Lewin's change theory was used as a guidance tool. Lewin's change theory framework with unfreezing, moving, and refreezing allows for the understanding of nurses behavior during the change process. In addition, there were several sources stated earlier that support improvement of communication during hand offs.

A nurse's primary concern is the safety of patients. Effective communication is a necessary tool in minimizing client harm and maximizing quality of care. The CNL will continue to guide and develop this project at the clinic.

Leadership is an important role in life and an even more important role in the success of a nurse. To be a leader one must be creative. Creativity results from engaging in surroundings to seek new possibilities. For the best outcome of reflection, and the use of creativity, one should be as impulsive as possible in recording thoughts and feelings. Efficient clinical leaders are supposed to be able to help others to see and understand situations from various outlooks and

effective clinical nurse leaders must be willing to look for new ways of doing tasks and activities. The dynamics of being part of a team makes it difficult to identify the best way to resolve possible conflicts of interests and opinions. However, this is the responsibility of the leader. Identifying or highlighting an issue that has occurred on the job is an important attribute from a leadership's point of view. This enables one to share issues and promotes a reflective outlook which team members and/or management would all benefit from because it becomes knowledge gained. Along with leadership comes managing conflict. The issue of influencing others through delivery of meaningful information is a way of managing conflict. Another useful technique used when managing conflict is respect. Quality involves having regard for the signals that emanate from other individuals or being able to respect colleagues' opinions. This can be regarded as the most important tool for managing conflict. As frustrating as this may be, all team members have to take the time to listen to everyone's opinion and this is a time-consuming process because most individuals would want to use the first answer given rather than go through the tedious process of hearing from all team members.

As a CNL, it will be important to be flexible and responsible in the daily activities at the clinic. The experiences and knowledge acquired from the courses taken in the CNL program will last a lifetime and are invaluable. This assignment allowed this writer to reflect on what has occurred these past 7 semesters and the growth that occurred in this author's professional and personal life. Several of the CNL role functions from the End of Competencies were established, such as being an advocate for patients, being a member of a profession such as the American Nurses Association (ANA), and being a team manager and that involves working with individuals providing guidance and keeping everyone on track to finish the project or care of a

patient. Finally, as an educator, ensuring that staff are kept up to date with the most recent literature and information regarding patient care.

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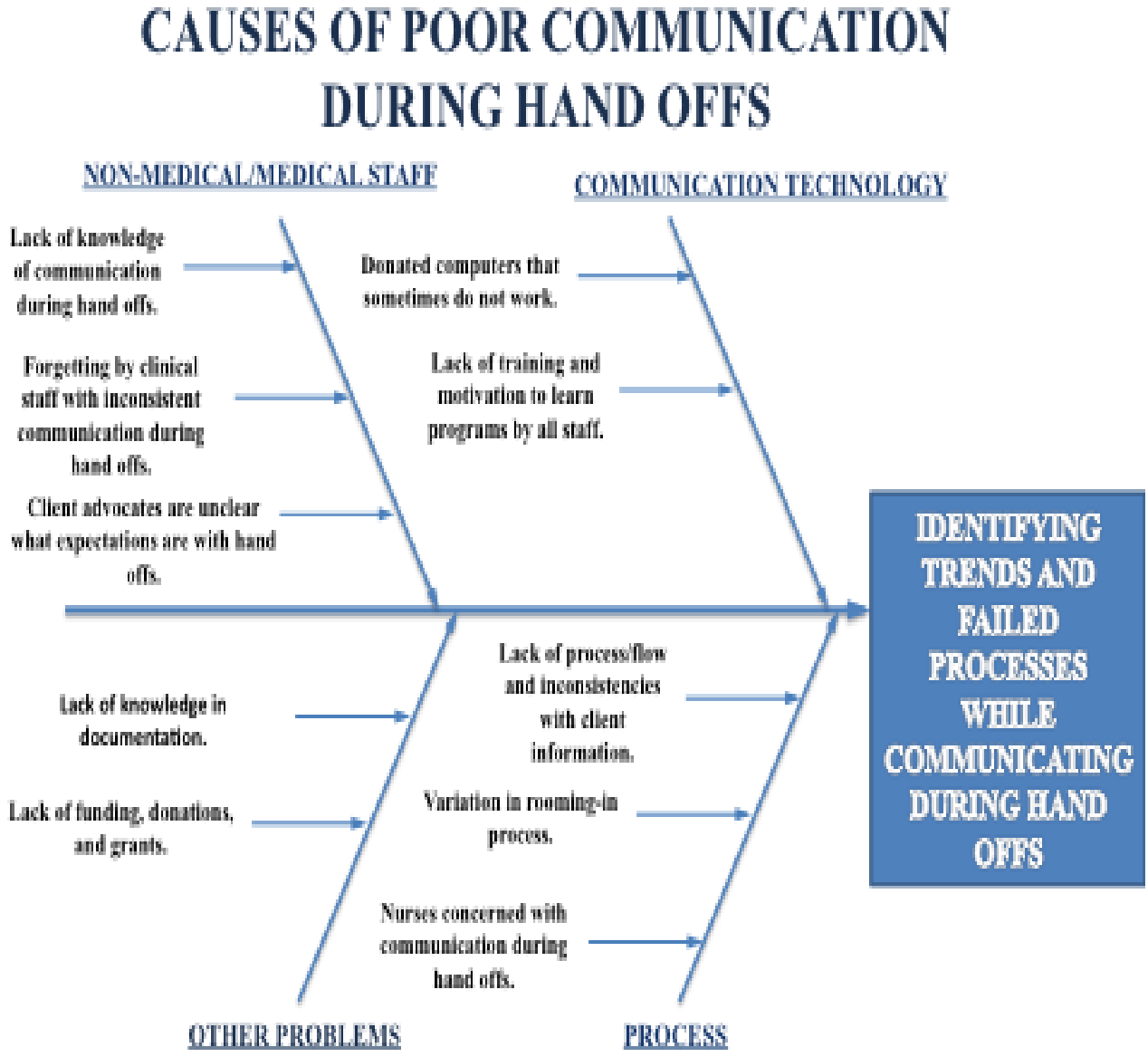
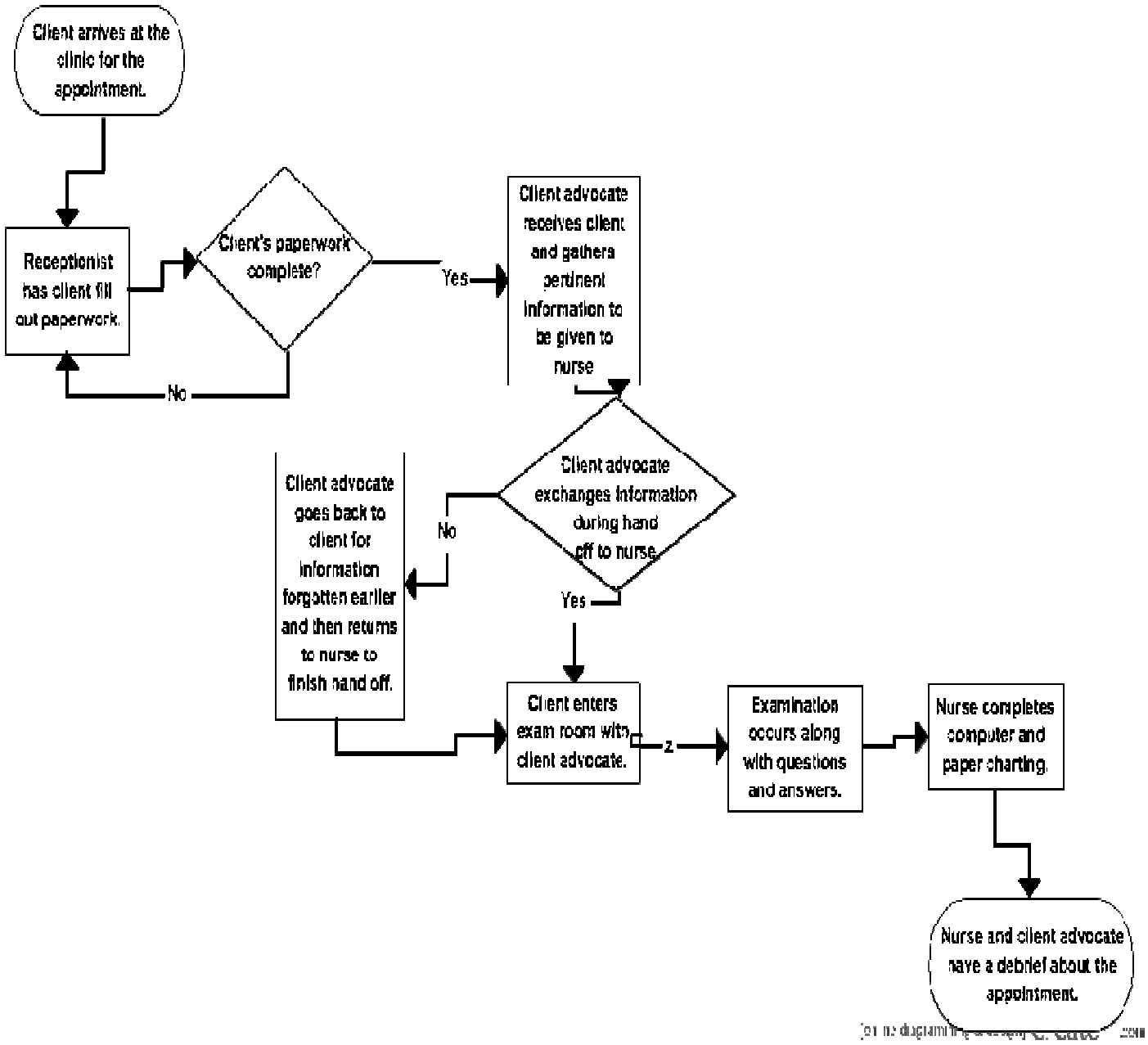
FISHBONE DIAGRAM



APPENDIX A

This diagram depicts the potential causes contributing to the trends and failed processes of poor patient outcomes related to poor hand off.

PROCESS MAP



APPENDIX B

This figure highlights the delay in transfer of client information to nurses. What this diagram does not show is the possible delays caused by older computers and nurses documenting by hand.

SWOT ANALYSIS

POSITIVES	NEGATIVES

INTERNAL	
STRENGTHS	**WEAKNESSES**
High staff morale High staff satisfaction Small clinic Small close knit clinic Provide quality patient care Open communication High collaboration	Lack of professional training for client advocates Limited knowledge of electronic health care documentation processes Communication inconsistencies Staff resistant to training Potential incentives that are not related to improvement of communication during hand offs
EXTERNAL	
OPPORTUNITIES	**THREATS**
Improve communication during hand off processes Improve documentation processes Seeking donations Seeking health record education to improve documentation processes Improve compliance with training Strong support from the community Recognition from the main local hospital	Nonprofit Donated equipment

APPENDIX C

This figure highlights the strengths, weaknesses, opportunities, and strengths.

GANTT CHART

		MONTH	MAY/JUNE						JULY				AUGUST			
ACTION ITEMS	**RESPONSIBLE**		**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Identify/Diagnose the problem	**CNL**		**X**													
Consult staff to evaluate interest in project	**All Staff**		**X**													
Global aim statement, flow chart, and fishbone diagram developed	**CNL/All Staff**		**X**	**X**												
Failure Modes Analysis Effect performed	**CNL**			**X**												
Specific aim statement developed	**CNL/All Staff**			**X**												
Literature Review	**CNL**			**X**	**X**	**X**	**X**	**X**								
Pre-implementation of hand offs	**All Staff**				**X**	**X**	**X**	**X**								
Weekly watching on adherence to process of communication during hand offs	**CNL**							**X**	**X**							
Ongoing educational and training reinforcement/support	**CNL**					**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**			
Post-implementation audits and evaluations/results and evaluate effectiveness of project	**CNL/All Staff**											**X**	**X**			
Terminate the helping process of the project	**CNL**												**X**			

APPENDIX D

This is the timeline for the implementation of the communication project pathways. This figure highlights the individual who is responsible for each action item, when it starts, length of time, and end of project.

PROJECTED COST ANALYSIS

APPENDIX E

FINANCIAL ANALYSIS

TABLE 1

COSTS/3 MONTHS	TOTAL COSTS
A. MAY 2015-AUGUST 2015 OVERTIME COSTS FOR NURSE AND CLINICAL DIRECTOR ($10,080 + $5,400)	**$15,480.00**
B. MAY 2015-AUGUST 2015 REGULAR COSTS FOR NURSE AND CLINICAL DIRECOTR ($6,720 + $3,600)	**$10,320.00**
C. TOTAL COSTS FOR 3 MONTHS	**$25,800.00**
D. TOTAL SAVINGS WITHOUT OVERTIME (C-B=D)	**$15,480.00**

COST BENEFIT ANALYSIS

APPENDIX F

TABLE 2

ITEM	CALCULATION	INTERPRETATION
A. COSTS-NON-PERSONNEL EXPENSES FOR 3 MONTHS FOR MAY 2015-AUGUST 2015 ($45.00 PAPER EXPENSE $0.15/PAGE X100=15X3]	**$45.00**	**ESTIMATED COST FOR QUESTIONNAIRES EXPENSE**
B. BENEFITS	**$15,480.00**	**DOLLARS SAVED BY NOT HAVING OVERTIME**
C. NET BENEFITS (B-A)	**$15,435.00**	**POTENTIAL DOLLARS SAVED BY REDUCING OVERTIME AND IMPLEMENTING PROJECT**
D. BENEFIT/COST (B/C) RATIO ($15,480.00/$15,435.00)	**$1.00**	**FOR EVERY $1 SPENT ON THE PROJECT, THERE IS A SAVINGS OF $1.00**

Client Hand-off and Assessment Form

For Medical Services

Client Name: _____Date:_____

File #:_____

Status: Divorced/Engaged/Living Together/Married/Never Married/Remarried/Separated/Single/Widowed

Other: _____ Here Alone: Yes___ With Whom _____Alone ___

Medi-Cal: Yes___ No___ Needs to Apply___

Insurance: Client Covered____ Needs Coverage____ Name of Insurance and Number

_____

Client's Stated Main Concern(s) to be Here: _____

_____

_____

Medical Concerns or Questions

Concerns:_____

_____

_____

Medical Questions

Asked:_____

_____

_____

_____

Date of Last Physical Exam: _____ Last Menstrual Period (LMP):_____

Any Abuse: Physical___ Emotional__

STD

Prior History: AIDS__ Chlamydia__ Crabs__ Genital Warts__ Gonorrhea__ Herpes__ HIV__ HPV__ Syphilis __ Other __

Client at Risk: Yes__ No__ How Many Partners: ____ When Last Tested: _____ Pos:__ Neg:__

Abortion Procedures and Risk Requested by Advocate

Advocates Initial Assessment (Before Testing)

1. What is your initial assessment of the client's abortion intentions before her visit?
   Abortion Minded__ Abortion Vulnerable (Undecided) __ Carry to Term (Parent) __ Adoption__

2. What is your assessment of the client's abortion intentions after her visit?
   Abortion __ Abortion Vulnerable (Undecided) __ Carry to Term (Parent) __ Adoption__

3. What is the client's stated intentions after support?
   Abortion __ Abortion Vulnerable (Undecided) __ Carry to Term (Parent) __ Adoption__

APPENDIX G

Exit Survey

We strive to provide the best service possible to our community. As someone who has received our services, your opinions are important to us. Please take a moment to answer the following questions, so that we may continue to provide the best service possible. Respond to each question using a scale of 0-4. Please circle the answer. Thank you.
0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

1. When you called Alpha Clinic, was the receptionist helpful while talking to you and setting the appointment?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

2. Upon your arrival at Alpha Clinic, was the receptionist considerate upon greeting you?
   0=Excellent 1=Very 2=Somewhat 3=Minimally4=Not at all N/A=Not applicable

3. Was the counseling room comfortable?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

4. Was the Advocate sensitive and respectful towards your needs?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

5. Did you feel pressured in any way?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

6. Did you feel comfortable sharing your concern with your Advocate?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

7. Were the educational materials used, helpful in informing you about your options?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

8. Did you receive the information and assistance you needed to make an informed decision?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

9. How likely are you to refer Alpha Pregnancy Clinic to a friend?
   0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

10. Did the medical staff seem interested in you and your needs?
    0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

11. Was the medical staff sensitive and respectful of your beliefs?
    0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

12. Were your concerns addressed by the medical staff?
    0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

13. Were your questions answered by the medical staff?
    0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

14. Were you seen in a timely manner?
    0=Excellent 1=Very 2=Somewhat 3=Minimally 4=Not at all N/A=Not applicable

15. What information did you gain from this appointment? _____
16. Do you have any suggestions for improvement? _____
17. Please share any comments; even if they are negative, we want to be respectful and helpful to the women that come into our clinic._____

Please write on back of paper for questions 15-17.

APPENDIX H