

The University of San Francisco

USF Scholarship: a digital repository @ Gleeson Library | Geschke Center

Master's Projects and Capstones

All Theses, Dissertations, Capstones and
Projects

Winter 12-16-2022

Standardizing Handoff Report in a Medsurg Telemetry Floor

Brandon Tyler Thompson

University of San Francisco, btthompson@usfca.edu

Follow this and additional works at: <https://repository.usfca.edu/capstone>



Part of the [Other Nursing Commons](#)

Recommended Citation

Thompson, Brandon Tyler, "Standardizing Handoff Report in a Medsurg Telemetry Floor" (2022). *Master's Projects and Capstones*. 1449.

<https://repository.usfca.edu/capstone/1449>

This Project/Capstone - Global access is brought to you for free and open access by the All Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Master's Projects and Capstones by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

Standardizing Handoff Report in a Medsurg Telemetry Floor

Brandon Thompson

Department of Nursing, University of San Francisco

NURS 648: Healthcare Policy and Ethics

Abstract

Problem: Hospital A's 9th floor telemetry units lacked a standardized method of handoff and required investigation. Current practices were evaluated, and an intervention was designed based on weak communication areas. **Context:** Using a 5 P's assessment the key stakeholders included unit nurses, the nursing director, nurse educators, and unit nurse managers, and the patients were med surg telemetry patients. The process included handoff in care and the pattern evaluated was methods of reporting with the purpose of providing high quality evidence-based patient centered care. A SWOT analysis revealed strong teamwork, interdisciplinary collaboration, and proficiency in health record technologies as strengths and driving forces that would aid change. Short staffing, burnout, poor leader buy-in and limited time acted as barriers to implementing change. **Interventions:** An education presentation was developed highlighting and providing examples of critical SBAR, TRACER, and centralized EHR reporting tools. The slideshow was designed to allow for nurse educators to further develop a communication education plan for unit nurses. **Measures:** Initial data collection included using a survey, observing, and individual interviews. A post survey accompanied the education intervention so impact can be evaluated. **Results:** 10 survey responses were collected. Main themes from data collection included a need for clarity, efficiency, and conciseness. Unit nurses utilized a variety of evidenced-based communication methods; however, there lacked consistency and there was little bedside reporting.

Conclusions: Based on similar quality improvement studies further development of this handoff education intervention is likely to show better standardization in communication, more satisfactory handoff reporting between nurses, and fewer patient care errors related to miscommunication.

Keywords: handoff; reporting; SBAR; TRACER; EHR; communication tools;
communication errors; nurse; education

Standardizing Handoff Report in a Medsurg Telemetry Floor

Introduction

Effective communication is an essential basic skill in the nursing profession. Nurses are expected to summarize a situation swiftly and succinctly and clearly articulate it to the physician, nurse coworker, social worker, etc. This ability is taught early on in nursing school and is honed upon graduation. Yet, poor communication is frequently the reason for medical errors. In 2016 communication failures in U.S. hospitals and medical practices were responsible for at least 30% of malpractice claims, resulting in 1,744 deaths and \$1.7 billion in malpractice costs over five years (Joint Commission, 2017). Inadequate hand-off can cause dire consequences to patients and can have high financial costs on hospitals. Other adverse effects resulting from ineffective communication can include wrong-site surgery, delay in treatment, falls, and medication errors (Joint Commission, 2017). These examples of adverse events demonstrate the decrease in quality of care when poor hand-offs occur.

Problem Statement

For this quality improvement project Hospital A requested an analysis of their 9th floor telemetry units. The hospital reported a lack of standardization of report and a lack of data on communication methods currently in place by nurses. The nursing director of Hospital A tasked the quality improvement team with evaluation of current practices and an implementation of an intervention to improve handoff report where needed. The 9th floor included an East and West unit with a total of 50 beds. Points of analysis included both inter-unit communication and intra-unit communication. This project is a change in current practice at Hospital A and employs current evidence-based practice as noted in the Statement of Determination (Appendix A). After

reviewing the IRB non – research determination checklist (Appendix B), it is indicated that this project is a quality improvement project and is not considered a research study.

Literature Review

There are various methods implemented to maintain effective hand-off communication. One of the most common methods include SBAR or Situation, Background, Assessment, and Recommendation. This communication technique is most frequently taught to nurses and is meant to standardize communication between the nurse and any other healthcare team member. SBAR is formatted to contextualize a patient, present the current situation, note the nurse's actions, and invite collaboration on next steps. The use of SBAR has been shown to be effective across medical disciplines, improving confidence of the user, shortening report time, and strengthening accuracy of exchanged information (Stewart, 2017). Along with a regularly practiced communication tool, individual personalization adds comfortability when presenting information. However, in some cases personal preferences in communication methods have been shown to disrupt handoff report (Rhudy et al., 2022). When too much personalization occurs during handoff report, there becomes a loosening of structure and important information can be lost.

Therefore, not only should inter and intra disciplinary communication be standardized, but also there is a need for tailoring based on each unique care setting, which can be assessed based on a macro or micro scale. Rhudy et al. (2022) have found that hand-off elements are often defined by practice and unit culture. Because personal habits during report depend on the unique environment, specific standardization solutions are needed to maintain efficacy. In one hospital a tailored intervention was implemented utilizing a modified SBAR format, which included an introduction, and Connect, Ask, Respond, Empathize (CARE) protocol (Chien et al., 2022).

Their personalized intervention showed better communication and culture across the ward, and there was an associated decrease in hospital acquired complications (Chien et al., 2022). By creating a specific standardized hand-off method that was accepted by unit staff, communication was improved, and adverse events were minimized. These examples emphasize the importance of specifically tailoring verbal reporting based on the needs and culture of each microsystem.

While adjusting communication methods to the culture is important, simply improving critical reasoning skills is paramount to giving a good report. By improving critical reasoning, the healthcare professional can better understand the problem at hand and can identify essential information. When essential information is identified communication tools are more effective. For example, in order to effectively utilize SBAR the background information provided must be clear and concise. Park (2020) states that in this section it is crucial to give information relevant to the situation; otherwise, information overload can lead to fragmented handovers. Honing critical reasoning skills so the individual is clear and concise is crucial in both emergency situations and casual reporting.

Additionally, bedside reporting is a practice that includes the patient in the hand-off process. There are several advantages to bedside reporting that benefit both the nurse and the patient. First, nurse to nurse bedside handoff has been shown to increase patient satisfaction and nurse satisfaction in regard to communication about the plan of care (Maxson et al., 2012). This type of report centers the patient and makes for a more patient centered experience. Not only is patient satisfaction improved but also safety risks are reduced when using patient-centered bedside handoff (White-Trevino & Dearmon, 2018). There are clear benefits to the patient when bedside handoff is utilized. In fact, synthesizing standardized handoff tools like SBAR with bedside report can improve communication with patients in addition to other medical staff,

reducing adverse hospital events with patients (Abbaszade et al., 2021). Overall, including standardized report at the bedside is shown to positively impact patient satisfaction, center the patient, and decrease the occurrence of medical errors. In a greater sense these solutions for standardizing communication can benefit all the stakeholders involved.

Along with bedside report there is current practice revolving around line and tubing safety. One technique that ensures patient IV/tubing safety is described as trace, read, affix, connect, examine, and retrace (TRACER). TRACER is a form of line reconciliation that is performed at the bedside during nurse-to-nurse handoff. The nurse is able to trace existing lines from source to site, read existing line labels and affix labels where needed, connect and examine compatible lines, and retrace from source to site to confirm accuracy. TRACER improves patient safety and can avoid infusion errors and dangerous misconnection errors (SHARP, 2015). This reporting tool can be easily adopted into the bedside reporting practice while maintaining patient safety and clear communication.

Lastly, augmenting handoff with electronic health record (EHR) based tools can bolster effective communication. Majority of hospitals use some form of EHR as a way to organize essential health data. These EHRs often have additional functions that can streamline patient information. When EHR tools are used in conjunction with a verbal handoff report, there can be an improvement in communicating essential information. For example, Pandya et al. (2019) used an EHR called EPIC and developed a user-friendly tool to use in conjunction with verbal report, which followed the SBAR framework and assisted in standardizing workflow. Their findings showed an associated decrease in medication errors from 60% to 32%. This scenario offers another option at standardizing handoff and improving communication.

Altogether standardizing communication in medical settings is crucial in improving quality of care and safety. Providing a framework for verbally reporting information that is specifically tailored to each microsystem improves the satisfaction and culture of the environment. Likewise, standard communication tools like SBAR are versatile and can clarify communication at the bedside or be supplemented with an EHR tool. Without a uniform protocol for discussing important patient information, there runs a risk of adverse events that affect patient care. All in all, current research states establishing a standard of communication that is evidenced based can greatly benefit physicians, patients, and nurses alike.

Rationale

To best institute an intervention on the 9th floor units of Hospital A Kurt Lewin's change theory will act as a guide. Lewin's change theory has three stages consisting of unfreezing, change, and refreezing, and the major concepts that contribute to change include driving forces, restraining forces, and equilibrium (Petiprin, 2020). Driving forces positively impact change, restraining forces negatively impact change, and equilibrium stagnates change due to equal driving and restraining forces. In the unfreezing stage to stimulate change driving forces need to be stronger than restraining forces or restraining forces need to be reduced. When unfreezing occurs, the project enters the change stage where an intervention can be implemented. Adjustments to the intervention occur repeatedly to adjust for newly identified restraining forces. After the intervention is implemented efforts to solidify the change occur at the refreezing stage. At this point problems with the intervention have been addressed and behaviors are made commonplace and seamlessly integrated into the microsystem.

In the case of Hospital A, the unit nurses must unfreeze their communication habits and become amenable to new reporting methods. Some driving forces include strong teamwork and

collaboration, an openness to mentoring, and commitment to innovation. Some restraining forces can include nurse resistance to change due to short staffing and burnout. Also, a lack of leadership involvement may hinder progress. It is essential to involve unit nurse feedback and incorporate a seamless integration of the interventions to combat restraining forces.

Nevertheless, when habits are unfrozen then teachings about current evidence-based reporting practices can be disseminated throughout the units. Allowing for unit nurses to customize the intervention to the unit culture can help buy-in. Also, connecting with unit champions during the early intervention period can help champion change. These individuals can give key feedback on early trials and help encourage buy-in from other unit stakeholders. At the refreezing stage multiple education cycles will likely be necessary to instill change and combat resistance. At this point the intervention will have been personalized and barriers will have been addressed, so it can be comfortably adopted by staff. Refreezing will occur when there is unit buy-in, and the new behaviors will not be perceived as adding extra labor to handoff reporting. When refreezing finishes there is an expected improvement in communication, a reduction in adverse events, and strengthening in patient quality of care.

Project Aim

In looking at the needs of Hospital A, there first needs to be an identification of current reporting practices before an intervention can be chosen. However, there is a clear lack of standardization across the 9th floor units. Current research shows utilizing evidence-based reporting techniques like critical SBAR, bedside reporting, and EHR report tools, are effective in improving microsystem communication and patient safety. Keeping in mind best practice and the lack of standardization, Hospital A's 9th floor units will likely benefit from an intervention that uniformly implements reporting methods. Therefore, the quality improvement team asks, "for

telemetry nurses, how does utilizing critical SBAR, TRACER, and an EPIC transfer of care tool compare to standard SBAR handoff in improving nurse to nurse communication satisfaction?"

Methods

Context

Upon approaching Hospital A's 9th floor units, a five "P"s assessment was performed. The relevant professionals were identified as the unit nurses; however, other stakeholders include charge nurses, nursing managers, the nursing director, physicians, therapists, and nursing assistants. The processes the quality improvement team will analyze includes shift-to-shift handoff report. Other processes include medication administration, which includes oral medications, IV drugs, and blood products, health assessments, patient education, wound management, assisting with activities of daily living, etc. All processes have an impact on patient care and safety. The pattern from the process that will be evaluated is shift report handoff. Handoff occurs between each shift, which there are three shift changes in a day, and during any sort of patient transfer of care. A single nurse will participate in at least two handoff reports, one at the beginning of their shift and a second at the end of the shift, making good communication essential. The patients involved on these units are med surg telemetry patients. Finally, the purpose in this microsystem is to provide high-quality evidenced based care that is cost-effective by centering the patient with compassion and respect.

Before data collection a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis (Appendix C) was performed. The SWOT analysis was used to identify aspects of the microsystem that may support this quality improvement intervention and obstacles that may inhibit progress. In evaluating the strengths there was strong teamwork and communication

among nurses and other interdisciplinary stakeholders. Consequently, some identified opportunities for quality improvement were an openness to continued education and some interest in innovation. There was also a lack of standardization in handoff report creating a space for potential improvement. Some weaknesses noticed were burnout, short staffing, and comfortability in current communication practices. These aspects likely contributed to some resistance met from staff. Likewise, some threats were fueled by short staffing and burnout, making nurse and unit champion buy-in difficult. All these points of the SWOT analysis were considered when data collecting and designing the intervention.

Plan, Do, Study, Act (PDSA) cycles are a typical quality improvement tool used for introducing change into a microsystem. PDSA cycles can be performed at a small scale with a few individual stakeholders, and then expanded to an entire microsystem. For Hospital A, the plan phase consisted of data collection and identifying current handoff reporting trends across the 9th floor units. The do phase included the education intervention presented to the nursing director. The study phase involves a post survey to look at impact and change in practices on handoff habits. Finally, the act phase would adjust the intervention to educate staff and standardize communication methods more effectively. This PDSA cycle for Hospital A is repeatable and would likely require multiple cycles to instill lasting change.

The timeline (Appendix D) for this quality improvement project consisted of five parts. The first stage started in September 2022 and involved collaboration between the quality improvement team and nursing director of Hospital A to identify current needs and setting. Through October 2022 the second stage occurred where needs were identified, and the quality improvement team collected data on the 9th floor units. Between the end of October 2022 and November 2022 stages three and four occurred. In the third stage the quality improvement team

synthesized the data and presented trends and recommendations to the nursing director. At the fourth stage when feedback was received, the components of the quality improvement intervention was developed. Finally, after the intervention had been completed, the presentation was shown to the nursing director for future use and quality improvement.

When analyzing the practices of Hospital A's 9th floor several qualitative and quantitative dimensions were measured. Nurse satisfaction with shift report was evaluated to determine general attitude about current communicative practices. Also, frequency of bedside handoff was checked to see if patients were involved in report and if the method was positively impacting shift-to-shift pass-down. Report tools used were also tallied to evaluate current common handoff practices. Other dimensions included factors that make for an effective shift report and factors that make for an ineffective shift report. Finally, recommendations were collected to assess desire for change and areas in need of improvement.

When collecting nursing report data, a survey, individual interviews, and observational study was conducted. The survey (Appendix E) acted as a culture assessment and consisted of six questions with two being quantitative and four being qualitative. The first quantitative question asked nurse satisfaction with current report practices on a one-to-five-point Likert scale, one being the most unsatisfied and five being the most satisfied. The second quantitative question asked the nurse if bedside report was performed in "yes" or "no" format. The following four qualitative questions were all open response and asked which tools were used in report, effective/ineffective handoff experiences, and recommendations for better shift-to-shift report. To distribute the survey, unit managers and charge nurses were contacted, and an explanation of the quality improvement initiative was presented during huddle at shift transition. Afterwards

QR codes were distributed throughout the unit for the nurses to scan with their phones and access the survey.

When conducting individual interviews with unit nurses, the quality improvement team split up amongst the units and met at nursing stations. In the interviews, nurses were asked about feelings regarding current handoff practices, if bedside reporting was performed, current personal communication practices, and areas for improvement. As trends were noticed a question was added to the interview asking if report tools in the EHR were used during shift-to-shift hand-off. Individual interviews were conducted throughout the week and during morning and evening shift to contact various nursing staff who regularly worked on the units.

Continually, observational study occurred on the units by quality improvement staff. Team members were spread across 9th floor units throughout the week and during morning and evening shift. Team members observed nurses giving report and took notes on hand-off methods, effective practices, lapses in communication, missing crucial information, and if bedside report was performed. Data were compiled from both interviews and observations and trends were studied amongst the team. Trends and suggestions for improvement were then shared with the nursing director and unit managers.

Intervention

During the meeting with the nursing director, the quality improvement team presented the study data and highlighted areas for potential improvement. Afterwards the nursing director proposed an education intervention focusing on three handoff techniques. The first education topic discusses critical SBAR to address the current habit of giving too much information during report. Specifically, critical SBAR is a modified form of the traditional SBAR model meant to

succinctly communicate the most essential information about a patient, making for a swifter response to urgent patient problems. The second aspect of this intervention involves re-education about using TRACER to ensure safe IV lines and tubing. This verification process is meant to be done at bedside handoff with another nurse to ensure the oncoming nurse is responsible for current lines/tubing and can address any discrepancies. The third part to this education intervention explains using EPIC report tools alongside verbal report. The main points to educate nursing staff include the utility of using a central EPIC report tool and the directions for accessing the tool. It was also highlighted that the EPIC report tool can be customized to the needs of 9th floor microsystem. The education intervention was designed as a slideshow presentation for the nursing director. The quality improvement team incorporated the trends from the data collection phase, and then presented on the three education topics. The presentation was designed to be utilized by nurse managers and educators in the future for repeated quality maintenance of handoff report.

Study of the Intervention

Furthermore, a post-survey (Appendix F) was designed and presented to the nursing director for the purpose of collecting data on the impact of the intervention and to identify areas in need of adjustment. The materials given to the nursing director can then be presented to nurse educator staff to build a step-by-step change in practice. The education slideshow can be further utilized by nursing unit managers to teach nursing staff champions. Then the unit champions can demonstrate best practice and help convert other staff to the new methods. The education intervention is meant to be built upon and will likely need several PDSA cycles for full staff buy-in.

Measures

Measures to collect after intervention implementation includes nurse staff satisfaction, use of specific handoff tools, staff buy-in, and barriers to solidifying change. Nurse satisfaction with handoff report is evaluated similarly to the Plan phase, in that a survey will provide an assessment of unit attitudes. Use of specific handoff tools will be tallied to check if nursing staff is using the new handoff methods. Assessing staff buy-in could indicate comfortability with new handoff practices, which could help identify how easily staff are adjusting to the intervention. Lastly, noting barriers will help address resistance to learning and adopting these new handoff methods. Potential expected barriers to change could include nurse burnout, overloaded caseloads, limited time available to dedicate to learning, comfortability in current practices, or inability to link the intervention to quality improvement measures.

Results

Upon initiating data collection on Hospital A's 9th floor, a survey was distributed throughout the telemetry units. Despite regular reminders and redistribution of the QR code, the quality improvement team received only 10 responses. Even though there was a small response rate, some trends were noted. For the culture assessment (Figure 1), 60% of respondents indicated a satisfaction rating of four, indicating high satisfaction with some potential for improvement. After asking about bedside reporting (Figure 2) 60% of respondents stated they do not perform bedside handoff while 40% do perform bedside handoff, which is a close even split. However, considering bedside handoff is supposed to be a regular practice, this area needs improvement. The subsequent questions contained qualitative data (Figure 3) and allowed nurses to write-in their own answers. As far as reporting methods/tools used 60% mentioned using SBAR, 40% mentioned using TRACER, and 30% mentioned using EPIC. In the responses there was some overlap due to respondents being able to denote multiple handoff methods. While

SBAR appears to be common practice, supplemental reporting techniques are sporadically used. When asked about effective shift-to-shift reporting, 80% of responses indicated organization, conciseness, and clarity as contributing to a positive reporting experience. Likewise, 70% of respondents stated disorganization, “fluff”, and ineffective nurse tools contributed to negative shift-to-shift report experiences. These results highlight efficiency and clear communication as major themes for an effective handoff report desired by the microsystem. Lastly, when asked about improvements for current shift-to-shift reporting, 50% mentioned standardization, 50% mentioned better organization, and 30% mentioned more bedside reporting. Again, respondents were allowed multiple answers for this question.

Figure 1

Culture Assessment Using 5 point Likert Scale

Please rate your satisfaction on how shift-to-shift reports are currently being conducted.

10 responses

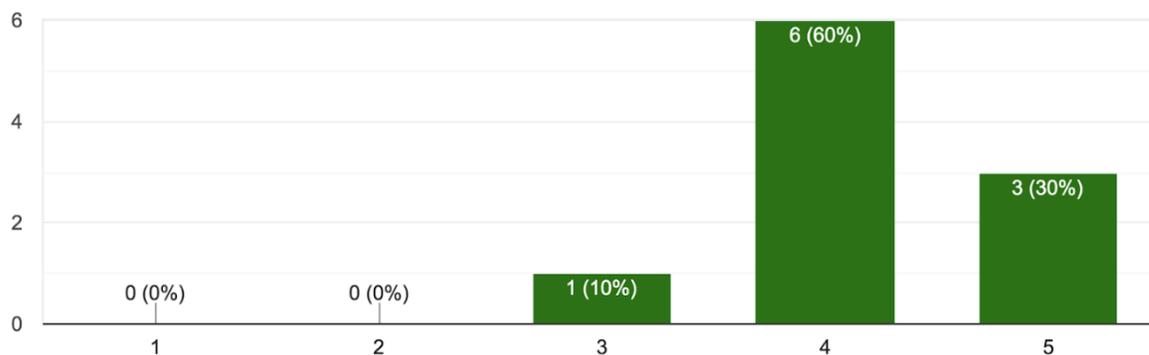


Figure 2

Nurses Who Perform Bedside Reporting

Do you currently conduct shift-to-shift report at the bedside?

10 responses

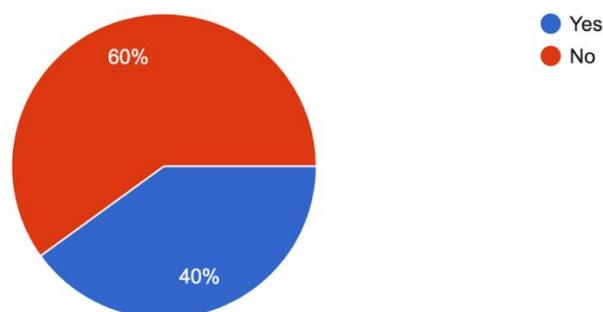


Figure 3

Qualitative Nurse Responses

Survey Question	Results
“What current methods/tools do you utilize to deliver shift-to-shift report?”	<ul style="list-style-type: none"> • SBAR – 60% • TRACER – 40% • EPIC – 30%
“What do you feel makes an effective shift-to-shift report, from your experience?”	<ul style="list-style-type: none"> • Organization, Conciseness, Clarity – 80% • Bedside Report – 10% • Includes Plan for the Day – 10%
“What do you think makes an ineffective shift-to-shift report, from your experience?”	<ul style="list-style-type: none"> • Disorganization, “Fluff”, Ineffective Nurse Tools – 70% • Incomplete Nursing/Patient Knowledge – 30% • Interruptions/Setting Issues – 30%
“What would you like to see be implemented differently during shift-to-shift report?”	<ul style="list-style-type: none"> • Standardized – 50% • More Bedside Reporting – 30% • Better Organization – 50%

Note: Some totals are more than 100% due to multiple answers by respondents for one question.

In addition to survey data collection, individual interviews and handoff observation was performed. From observation, nurses tended to use a loose SBAR format with personal preference heavily influencing their communication style. Bedside reporting after nurse-to-nurse reporting occurred on occasion. EPIC in conjunction with handoff was often used but not

consistently and majority of nurses could not find the official “handoff report” tool. Another noteworthy point mentioned by a nurse stated that bedside reporting was not performed due to frequent interruption by patients and family members. Overall, conciseness, efficiency, and clarity were the main themes for communication, and standardization of SBAR with supplemental handoff techniques are areas for improvement.

After data synthesis and presentation to the nursing director, the quality improvement team developed the education slideshow on evidence-based handoff communication tools as well as a post-intervention survey. The slideshow was meant to be a building block for future staff education and change in process. The nursing director gave positive feedback and noted the slideshow would be beneficial in conjunction with a step-by-step nurse communication education plan. The survey could be implemented with this education plan to evaluate impact on the units. Some adjustments in the slideshow were needed to provide clearer examples of SBAR communication. The nursing director then planned to present the slideshow and survey to nurse educators for further quality improvement development.

Based on current research educating on current best handoff practices is likely to improve unit communication satisfaction and reduce adverse events at Hospital A. Standardizing reporting using SBAR and understanding conciseness has been shown to reduce medication errors and improve accuracy in information being presented (Steward, 2017; Park, 2020). Likewise, regularly performing TRACER at the bedside with the oncoming nurse can improve patient safety (SHARP, 2015). When a central customized EPIC tool is used during handoff, further accuracy in patient information is expected (Pandya et al., 2019). Therefore, with continuation of this quality improvement intervention the expected results should show reporting standardization, positive nurse communication satisfaction, a reduction in medication errors, and

fewer sentinel events. However, due to initial nurse resistance to change, attributed to short staffing and burnout, repeated PDSA cycles will likely be needed to fully gain staff buy-in and instill the new change.

Discussion

Summary

After conducting the survey, the key findings of Hospital A's 9th floor telemetry units showed a lack of standardization and a hesitation to change. The unit nurses used varying forms of communication without any consistency. Through the survey and observation, it was clear that nurses were familiar with current evidence-based practice, such as SBAR, TRACER, and EHR reporting tools; however, they were sporadically utilized. Additionally, bedside reporting was occasionally performed and there was some indication it was avoided because of frequent interruptions. Majority of nurses cited organization and conciseness as beneficial to report while giving too much "fluff" as time consuming. With these results in mind, the quality improvement team identified standardization of report as appropriate for this situation, specifically teaching on useful handoff communication tools.

In collaborating with the nursing director, an education presentation consisting of critical SBAR, TRACER, and EHR report tools was created. These aspects were driven by the project rationale and specifically addressed our project aim. The three communication components chosen were relevant to both current research and the microsystem setting and are meant to be compared to current handoff practices. The education intervention is meant to be in transition from Lewin's unfreezing stage to the change stage because the educating aids in both making nurses understand the importance of standardizing their practice and introduces the new handoff

methods they should be implementing. The quality improvement project can then be continued to further enact change and ultimately standardize nurse communication with best practice.

Some limitations to the project involved time, lack of nurse leader championing, and nurse resistance to change. The overall timeline for the project extended across three months, which included data collection, problem identification, and then intervention implementation. Considering the aim to standardize multiple aspects of handoff report, three months was a major constraint. A six-month period would likely allow for more time to implement an intervention and run through several PDSA cycles to instill effective change. Also, more time would allow for better post-intervention data analysis. Furthermore, connecting and collaborating with other nurse leaders proved to be difficult. The nurse educator and unit managers were hard to contact and showed minimal buy-in to the project. The nursing director, the main champion and point of contact for Hospital A, was often unavailable, making it difficult to progress through the stages of this project. Likewise, nurses on the units were typically busy and showed little interest in changes to practice. This obstacle was seen in the low survey response despite repeated reminders. Many of these limitations were affected by Hospital A's staffing shortage and burnout, causing resources and attention to be diverted elsewhere.

On the other hand, the few meetings with the nursing director and the quality improvement team's adaptiveness contributed to the success of the intervention. When the nursing director was involved in the project, the feedback helped guide the direction of the team and narrowed the options for an intervention. Also, due to limited time with nurse leaders the quality improvement team was able to spend more time on data collection. The added time allowed for more extensive interviewing and observing on the unit. As a result, the quality

improvement team was able to better identify unit trends and culture. Ultimately leading to an intervention that shows strong potential for future development.

Conclusions

Altogether this quality improvement project has laid the groundwork for future unit evolution. By identifying current practices and areas of poor communication the project can be extended to further instill lasting change. Since the education presentation is completed, it can be presented to nurse educators who can design a step-by-step implementation plan. The slideshow contains evidence-based practices and supported research, so educators can use these points to teach nursing staff. From a broader perspective this project highlights the importance of standardizing nursing communication. Using research communication tools like critical SBAR, TRACER, and EHR reporting tools, can help achieve clearer handoffs, better organization, and uniformity in hospitals. For future continuation of this project, it is recommended that a more in-depth education plan be developed. It is essential that nurse leaders like directors, managers, and educators all have full buy-in. Multiple PDSA cycles should be performed starting with a small nurse sample size that includes unit champions and eventually expanding to the larger microsystem, adjusting for restraining forces along the way. Allowing room for some personalization to report may help with nurse buy-in and facilitate adaptation to the new change. Customizing a central EPIC reporting tool to the culture of the units may help fill this need. Post-intervention surveys and interviews should be conducted to identify newly emerging obstacles. Altogether standardizing handoff report with current communication methods can help strengthen the nursing team and ensure safety to the patients served.

References

- Chien, L. J., Slade, D., Dahm, M. R., Brady, B., Roberts, E., Goncharov, L., Taylor, J., Eggins, S., & Thornton, A. (2022). Improving patient-centered care through a tailored intervention addressing nursing clinical handover communication in its organizational and cultural context. *Journal of Advanced Nursing (John Wiley & Sons, Inc.)*, 78(5),
- Joint Commission. (2017). Sentinel Event Alert: Inadequate Hand-off Communication. *The Joint Commission*. Retrieved November 1, 2022, from <https://opqic.org/the-joint-commission-sentinel-event-alert-inadequate-hand-off-communication/>
- Maxson, P. M., Derby, K. M., Wroblewski, D. M., & Foss, D. M. (2012). *Bedside nurse to nurse handoff promotes patient safety*. MedSurg Nursing. Retrieved November 1, 2022, from <http://blog.aahs.org/wp-content/uploads/Bedside-Nurse-to-Nurse-Handoff-Promotes-Patient-Safety.pdf>
- Pandya, C., Clarke, T., Scarsella, E., Alongi, A., Amport, S. B., Hamel, L., Dougherty, & D. (2019). Ensuring effective care transition communication: Implementation of an electronic medical record-based tool for improved cancer and infusion. *Journal of Oncology Practice*, 15(5), e480-e489. <https://doi.org/10.1200/JOP.18.00245>
- Park, L. J. (2020). Using the SBAR handover tool. *British Journal of Nursing*, 29(14), 812–813. <https://doi.org/10.12968/bjon.2020.29.14.812>
- Petiprin, A. (2020). *Lewin's change theory*. Nursing Theory. Retrieved November 18, 2022, from <https://nursing-theory.org/theories-and-models/lewin-change-theory.php>
- Rhudy, L. M., Johnson, M. R., Krecke, C. A., Keigley, D. S., Kraft, S. J., Maxson, P. M., McGill, S. M., & Warfield, K. T. (2022). Standardized Change-of-Shift Handoff: Nurses' Perspectives and Implications for Evidence-Based Practice. *American journal of critical care : an official publication, American Association of Critical-Care Nurses*, 31(3), 181–188. <https://doi.org/10.4037/ajcc2022629>
- SHARP. (2015). *Sharp Healthcare Safety Training 2015*. SHARP.com. Retrieved November 18, 2022, from <https://www.sharp.com/instructors-students/upload/PATIENT-SAFETY-Mod-LINE-RECONCILIATION.pdf>
- Stewart, K. R. (2017). SBAR, Communication, and Patient Safety: An Integrated Literature Review. *MEDSURG Nursing*, 26(5), 297–305.
- White-Trevino, K., & Dearmon, V. (2018). Transitioning Nurse Handoff to the Bedside: Engaging Staff and Patients. *Nursing Administration Quarterly*, 42(3), 261–268. <https://doi.org/10.1097/NAQ.0000000000000298>

Appendix A

Student Project Approval: Statement of Determination

Title of Project: Standardizing Handoff Report in a Medsurg Telemetry Floor

Brief Description of Project: This quality improvement project aims to standardize nurse to nurse handoff report by implementing an education intervention on critical SBAR, TRACER, and EHR report tools. As a result, this quality improvement project will look to increase nursing satisfaction with handoff report and decrease medical errors related to miscommunications. This project improves upon already existing processes and employs already researched and accepted best evidenced based practice.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

(<http://answers.hhs.gov/ohrp/categories/1569>)

This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Students may proceed with implementation.

Comments:

Signature of Supervising Faculty _____ (date) _____

Signature of Student *Brandon Thompson* (date) 11/29/22

Appendix B

IRB Non-Research Determination Checklist

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST * STUDENT

NAME: Brandon Thompson **DATE:** 11/29/22

SUPERVISING FACULTY: Scout Hebinck

Instructions: Answer YES or NO to each of the following questions:

Project Title: Standardizing Handoff Report in a Medsurg Telemetry Floor

	Yes	No
The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.	x	
The project is NOT designed to follow a research design, (e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	

The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and agency oversight committee are comfortable with the following statement in your methods section.	x	

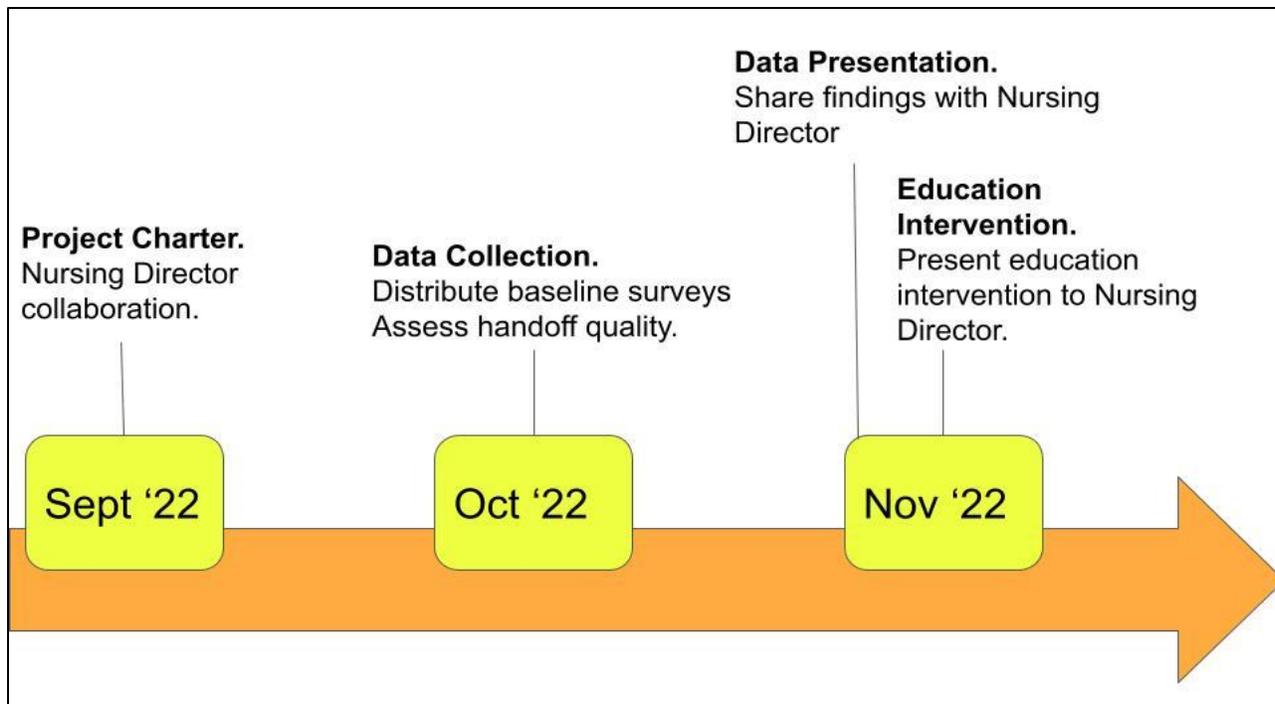
Appendix C

SWOT Analysis of Medsurg Telemetry Microsystem

<p style="text-align: center;"><u>Strengths</u></p> <ul style="list-style-type: none"> ◇ Strong teamwork ◇ Communicative albeit not standardized ◇ Good interdisciplinary collaboration ◇ Nurse mentor programs ◇ Proficient in EHR technologies ◇ Commitment to innovation 	<p style="text-align: center;"><u>Weaknesses</u></p> <ul style="list-style-type: none"> ◇ Nurse pushback to change ◇ Comfortability in personal preferences ◇ Short staffing ◇ Burnout
<p style="text-align: center;"><u>Opportunities</u></p> <ul style="list-style-type: none"> ◇ Open to educating team members ◇ Lack of standardized report practices ◇ Some nurses are interested in quality improvements to the unit 	<p style="text-align: center;"><u>Threats</u></p> <ul style="list-style-type: none"> ◇ Lack of nurse leader buy-in ◇ Limited time for intervention implementation ◇ Limited staff buy-in due to burnout and short staffing

Appendix D

Hospital A Quality Improvement Intervention Timeline



Appendix E

Current Handoff Practices & Culture Assessment Survey

Question:	Type of Response:
“Please rate your satisfaction on how shift-to-shift reports are currently being conducted.”	<ul style="list-style-type: none"> • 5-point Likert scale with 1 being most unsatisfied and 5 being most satisfied
“Do you currently conduct shift-to-shift report at the bedside?”	<ul style="list-style-type: none"> • Yes or No
“What current methods/tools do you utilize to deliver your shift-to-shift report? (ex. EPIC, SBAR, AIDET, TRACER, etc.)”	<ul style="list-style-type: none"> • Fill in the blank
“What do you feel makes an effective shift-to-shift report, from your experience?”	<ul style="list-style-type: none"> • Fill in the blank
“What do you think makes an ineffective shift-to-shift report, from your experience?”	<ul style="list-style-type: none"> • Fill in the blank
“What would you like to see be implemented differently during shift-to-shift report?”	<ul style="list-style-type: none"> • Fill in the blank

Appendix F

Post Intervention Survey

Question:	Type of Response:
"What is your unit?"	<ul style="list-style-type: none"> • Fill in the blank
"What shift times do you work?"	<ul style="list-style-type: none"> • Fill in the blank
"Please rate your satisfaction on how shift-to-shift reports are currently being conducted."	<ul style="list-style-type: none"> • 5-point Likert scale with 1 being most unsatisfied and 5 being most satisfied
"Do you currently conduct shift-to-shift report at the bedside?"	<ul style="list-style-type: none"> • Yes or No
"Do you use critical SBAR during report?"	<ul style="list-style-type: none"> • Yes or No
"Do you use TRACER during report?"	<ul style="list-style-type: none"> • Yes or No
"Do you use EPIC handoff tools during report?"	<ul style="list-style-type: none"> • Yes or No

“What is your preferred report method (ex. EPIC, SBAR, TRACER, etc)?”	<ul style="list-style-type: none">• Fill in the blank
“What has made for an effective handoff report?”	<ul style="list-style-type: none">• Fill in the blank
“What has been ineffective during handoff report?”	<ul style="list-style-type: none">• Fill in the blank
“Any recommendations to improve communication on the unit?”	<ul style="list-style-type: none">• Fill in the blank