

Improving Nurse-Nurse Handoff Communication

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Introduction

Nurse-nurse handoff denotes the transference of clinical expert accountability and responsibility for the specific or general aspects of care of an individual or group of patients from one professional to another on either a permanent or a temporary basis. Handoffs pervade the healthcare system and transpire during discharge, referrals, and admissions when patients are transferred between and within healthcare facilities, when clinicians take breaks, and at shift changes. Effective communication ensures patient safety and the continuity of quality care after the handoff process. Nevertheless, a large percentage of hospitals are liable to different medical errors that stem from the breakdown of communication during nurse-nurse handoffs.

Problem and Knowledge-Focused Triggers

The aim of this paper is to improve nurse-nurse handoff communication using IOWA model headings to enable the delivery of detailed information. Although handoffs are critical in transferring patient information and clinician accountability between care providers, there are moments of potential risk to patient safety which prompt adverse events. The breakdown of communication causes numerous medical errors such as missing or incomplete information, incorrectly prescribed or regulated medication, and gaps in health care since it fails to provide a practical foundation for patient care. Galatzan and Carrington (2018) cite previous studies, which indicate that communication issues during handoffs are responsible for approximately 60% of preventable adverse events that affect patient safety. Recent patient safety literature has ascertained that nurses have an essential role in guaranteeing effective communication during handovers to influence and improve patient outcomes by ensuring appropriate provider

coordination. Some of the factors that hinder the ability of patient handover to facilitate the excellent practice essential to upholding the high standards of clinical care include a lack of formal systems and proper training (Ramsay et al., 2018). Therefore, nurse-nurse handoff communication during work shifts is a critical process that, when done correctly, promotes the protection of patient safety. Furthermore, the clinician should focus on providing detailed, accurate information, as well as updated and relevant data from which the oncoming nurse can gain a sufficient understanding of a patient's health.

Literature Review

The nurse-nurse handoff process often occurs within a span of one to three and a half minutes per patient through either verbal or in-person techniques. Blondon et al. (2017) hold that verbal communication encompasses the use of several types of supporting tools, namely handwritten notes, the printouts of nursing tasks, postoperative prescription forms, the patient information board, and the EHR dashboard. Handwritten notes encompass the use of personal records that nurses are given during handoffs, while the printouts of nursing tasks incorporate a printout of the task list for every patient, comprehensively documenting the medication being applied and any additional data relating to the patient's care. Postoperative prescription forms denote paper documents that contain the postoperative prescription(s) necessary in the recovery rooms, while the patient information board offers an outlay of the ward, and the electronic health record (EHR) dashboard provides an overview of a patient's information (Buurman et al., 2016). The miscommunication that occurs during the exchange of information in verbal and written form causes adverse events.

Factors that limit effective communication during nurse-nurse handoffs include inconsistent documentation, a lack of a care plan, variable communication patterns, and the occurrence of interruptions. According to Blondon et al. (2017), the main barrier to effective handoffs is frequent interruptions by fellow members of the staff, which hinder the useful relay of information from one nurse to another. Inconsistent documentation due to a lack of time and high patient acuity turnover impede the development and evaluation of care plans and the effective conveyance of information concerning a patient's status to other healthcare providers (Johnson et al., 2015). Not having a plan of care affects the handover process, since nurses encounter delays in treatment and discharge, while the variable communication patterns determine the quality of the handoff process.

To improve nurse-nurse handoff communication, stakeholders should focus on four strategies, namely standardization, communication patterns, and electronic tool usage and memory/cognition. Organizations should standardize their handoff communication process through the provision of a structured sequence of information that guarantees consistency through different models (Jain and Yadav, 2018). This approach decreases information overload, reduces the risk to patient safety, enhances the quality of information exchanged, and improves patient outcomes overall. Communication patterns should involve the use of more than one network system that guarantees effective handoff for both day and night shifts while using written, verbal and non-verbal techniques (Galatzan et al., 2018). Since nurses currently believe that the EHR and other electronic tools interfere with the flow of information, it is critical to integrate these tools with the nurse's memory and cognition.

Resolution

The use of processes that identify the causes of nurse-to-nurse handoff miscommunication, prevent the associated failures, eliminate barriers, and improve the system is critical. The methods help with the identification, implementation, and validation of solutions that can enhance performance. First, healthcare facilities should demonstrate a commitment to leadership that guarantees successful handoffs and thereby increases safety (Blondon et al., 2017). To achieve these objectives, the focus of the institutions should be on improving their systematic approach to handoffs, providing the time, support, and financial resources needed to improve such initiatives and develop successful handoff strategies. Secondly, nurse-to-nurse handoffs emphasize the necessity of face-to-face communications in locations free from interruptions, allowing them to ask questions and minimize disruptions (Alert, 2017). The hospital should have a consistent place and time for sign-outs, establish a workplace conducive for sharing patient information, provide the nurses' contact information, and develop systems to share and receive data.

Thirdly, healthcare facilities should standardize the content that senders communicate to receivers during handover, both in written form and verbally. According to Alert (2017), the standard tools for ensuring that nurses focus on the critical aspects of safety care include protocols, forms, checklists, and templates, among other mediums. The process of standardizing content entails communicating and receiving handoff content in a timely way to guarantee the provision of proper care and services and integrating the use of electronic communications and real-time communication (Galatzan and Carrington, 2018). Other techniques of standardizing content involve synthesizing data from separate sources and guaranteeing that handoff

information encompasses critical content such as patient summary, illness assessment, and the sender's contact information.

Fourthly, hospitals can improve nurse-to-nurse communication by standardizing training on how to conduct the process. Galatzan and Carrington (2018) report that this would consist of the implementation of engaging staff training through techniques such as performance feedback, identifying champions, and employing trainers to encourage quality improvement. Moreover, it involves encouraging staff members to take the time and opportunities needed to seek clarification, as well as emphasizing concepts such as teamwork, situational awareness, and trust. Lastly, healthcare systems should combine the use of EHR and other technologies, such as telehealth and patient portals (Alert, 2017). These techniques facilitate communication and feedback between receivers and senders and support transparency and efficiency through online patient portals.

Implementation Plan

Detailed planning and gradual implementation are essential for ensuring the success of the project; thus, the roles played by different clinical and support staff are critical. Since different units in hospitals vary in terms of the techniques used in conducting the handoff process, it is essential to consider staff roles based on both the features of the healthcare organization and the individual units (Gagnier et al., 2016). Notably, the new practice will be tailored to meet the needs of different operating methods as this will enhance patient safety. Moreover, healthcare institutions should define the roles of each staff member clearly to strengthen every worker's understanding of the changes that the handoff process will undergo

(Alert, 2017). Next, the implementation plan should focus on determining ways of putting the resolutions into operation by focusing on strategies for defining roles and organizing work to incorporate the practices. Gagnier et al. (2016) argue that the process of putting the resolutions into practice focuses on redefining the preliminary implementation plan and obtaining the assurance of support from key stakeholders. Furthermore, it focuses on the initiation of a plan to pilot test the new practices, the application of the aforementioned strategy for engaging staff, and the devising of education plans to help staff learn an original method.

The Monitoring and Analysis of Outcome Data

The monitoring and analysis of the implementation process involves the development of a process that will gather feedback from staff and clinicians regarding the new nurse-to-nurse handoff practices. The monitoring process should include tracking changes in the assessment, incidence, prevalence rates, and communication of results to staff members (Alert, 2017). Other factors to consider involve assessing the effectiveness of the teams in practicing resolutions and collecting data to examine any possibility of performance improvement.

Evaluation and Dissemination

To evaluate the impact of the change within the institution, the healthcare organization's management should calculate the handoff practices before and after implementation of the change process and then measure the results. Afterward, the institution should assess if the new practices meet the desired outcome and if the quality of communication during the handover process has improved Gagnier et al. (2016). Then, the organization should evaluate if the changes have had positive impacts on patient safety.

Conclusion

In brief, those involved in nurse-to-nurse patient handoffs are faced with the challenge of miscommunication, which, due to medical errors, affects patient safety. To counter the problem, healthcare facilities should demonstrate a commitment to leadership that guarantees successful handoffs, emphasize face-to-face communications to prevent disruptions, and allow caregivers to ask questions. Another strategy encompasses the standardization of the content that senders communicate to receivers during handover, improving nurse-to-nurse communication by systemizing their training and combining the use of EHR and other technologies.

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