Handoff of Care on a Busy Rehabilitation Unit: Developing a Structure for Multiple Daily Handoffs RN/Therapist

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Background/Significance

Gaps in communication may cause avoidable safety risks. Sometimes collegiality among team members promotes a level of comfort that can create false assumptions about shared knowledge.

Handoffs are used to provide accurate information about a patient's care including:

- **treatment and services**
- **current condition**
- **any recent or anticipated changes**

Purpose is to share important information to ensure and maintain continuity and quality of safe patient care

Statement of the Problem

Busy 18-bed inpatient pediatric rehabilitation unit

Requires frequent (6-10) transitions from RN to other interdisciplinary team members:

- **Physical therapist (PT)**
- **Speech language pathologist (SLP)**
- **Occupational therapist (OT)**

Because of the frequency of daily transitions of care and familiarity among team members, handoff information was assumed or occurred by exception.

Other key factors potentially affecting patient performance and safety during therapies such as quality of sleep, anxiety, or fatigue, were not consistently discussed among team members throughout the day.

A sudden trend of safety events (6 safety events recorded March, 2013 to July, 2013) with potential safety risks caused us to reconsider our communication structure, pointing to a need to develop a standardized process for handoffs of care between the nurse and therapist(s).

PICO Question

For patients on the Pediatric Rehabilitation unit, will creating a standardized process for hand off between nurses and therapists compared to handing off by exception, result in a decrease in safety events?

Methods

Formed an interdisciplinary group composed of Nursing, PT, OT and SLP to review safety event data and begin an improvement process (June, 2013-July, 2013)

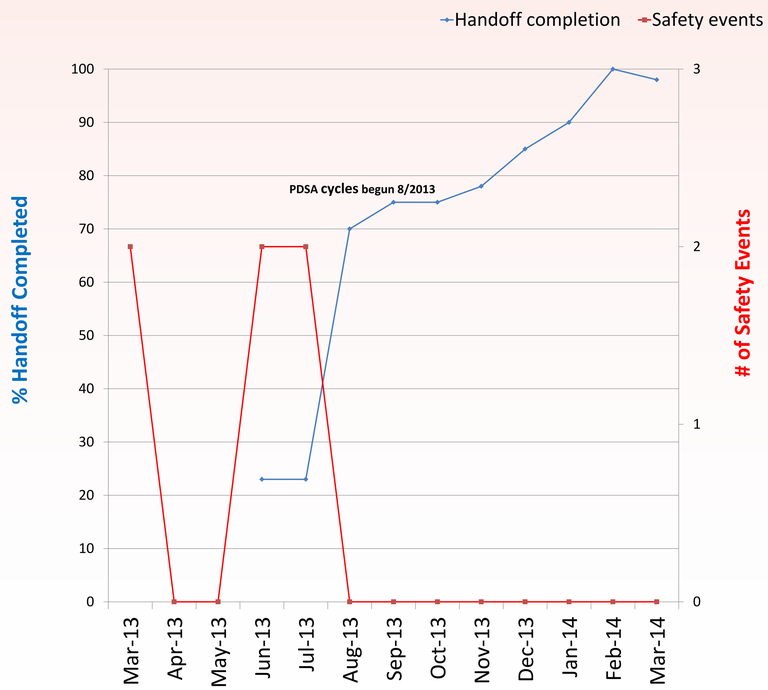
Baseline data regarding handoffs between nurses and therapists collected (June-July, 2013)

Charter and Driver diagram developed to determine areas for improvement

Small tests of change begun to address areas for improvement (August , 2013)

- **Reference cards outlining key communication points developed to be used by all staff during handoff**
- **Therapists provided with easy access to RN patient assignments to be able to easily identify the nurse caring for the patient they were working with**
- **Handoff to occur whenever patient left/returned to unit**
- **Handoffs could occur in person or via pager/phone for ease of communication**

Handoff Completion/Safety Events



Outcomes

Baseline data initially indicated handoffs between nurses and therapists were occurring < 30% of the time.

Success of PDSA cycles over time indicated that by January, 2014 handoffs were occurring >90% time

Successes :

- **Increased communication in a structured format**
- **Safer patient care i.e. no safety events since improvement work started**

Challenges :

- **RN receiving numerous calls throughout day**
- **Quality of handoffs not always effective; " nothing to report" "everything is fine"**

Since the start of this improvement project there have been no safety events related to a hand off of care on the Rehabilitation unit.

Current Status

January 2014 : Spread process to include additional health care providers (HCP) -Child Life Specialist, Music and Art therapists, Teachers, Psychologists

February 2014 Staff survey results: 1) perception of improved patient safety; 2) handoff process needs to be more streamlined, efficient and meaningful.

March 2014: Quality Measures determined. Handoffs will include specific topics: sleep; medical changes; patient needs during therapy sessions.

June –August 2014: PDSA cycles demonstrated increasing compliance with reporting on standardized measures

Implications for Nursing Practice

Improving communication during hand off of care helps to minimize preventable safety risks. Nurses have a standard for handing off to each other ; when multiple disciplines are routinely involved in a patient's care, a similar process can be effectively implemented.