Inspiring Change

Effective nurse handoffs: Key considerations for design and implementation

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Nurse handoffs are the transfer of responsibility and accountability between nurses at the beginning and end of every shift. Also called shift reports, these involve the communication of a patient's current status, plan of care, and other critical information such as pending lab results. The goal is to promote continuity of patient care between the offgoing nurse (sender) and the oncoming nurse (receiver). In a single 30-bed hospital unit with 12-hour shifts, 60 handoffs occur each day—which translates to 21,900 handoffs per year. This frequent and complex activity presents numerous possibilities for communication failure in patient care that would have major implications on patient safety and outcomes as well as on the effectiveness, efficiency, and timeliness of care. The potential for patient harm is introduced when inaccurate, incomplete, or unnecessary information is transferred to the oncoming nurse or the receiver.[1] Inaccurate handoff can negatively impact the continuity of care and lead to delayed or inappropriate treatment and prolonged hospital stay.[1]

Numerous barriers interfere with effective handoffs, including inadequate nurse education on effective handoffs, increased workload and time pressure among nurses, poor motivation among nurses who feel unappreciated, lack of a policy and standardized process, and the lack of leadership's commitment to successful handoff implementation.[1,2] Too much unit noise, reduced privacy, and frequent interruptions are also known to negatively impact handoffs.[3]

Successful nurse handoffs require the right preconditions, tools, and patient information delivered in the appropriate place using effective communication processes. This article takes an evidence-based approach to designing and implementing effective nurse-to-nurse handoffs.

Preconditions

An effective handoff process requires careful planning and a policy to guide the implementation. Smeulers and Vermeulen[3] noted that a nursing handoff blueprint must be tailored to the local context and consider research-based evidence on effective handoffs.

The first step is for nurse leaders to make successful handoffs a unit priority and identify specific barriers that prevent effective handoffs.[1] Including the nursing staff in the implementation and development of a standardized process increases the chance that the new process will be adopted and sustained.[3] It can also reduce any negativity from the staff about the change.

A handoff policy should provide instructions including the location, time, the standardized structure (such as an mnemonic or checklist), and the desired environment (for example, a space free of nonemergency interruptions). It should specify that a handoff is conducted face-to-face and include written and verbal components.[1] Ideally, the standardized handoff process is incorporated into the workflow of the electronic health record to guide the verbal exchange and eliminate wasting time by taking notes.[2]

Standardized training on how to conduct a handoff from the role of a sender and a receiver has been identified as key to success.[1] Champions and coaches are suggested to serve as role models to promote the process.[1]

Using effective tools

To be effective, a handoff tool must include patient-specific information that is clear, concise, patient-focused, and comprehensive. Mnemonics are cognitive aids to help standardize communication, aid recall, and ensure an error-proof process.[4,5] Nasarwanji et al.[6] identified 27 handoff approaches using mnemonics. However, a lack of evidence to support their effectiveness is concerning because even the most cited tools, such as the Situation, Background, Assessment, Recommendation (SBAR) and the I-PASS (Illness severity, Patient summary, Action list, Situational awareness and contingency plans, and Synthesis by the receiver), were developed outside of nursing. O'Rourke et al.[7] conducted a review of the literature confirming that SBAR and most handoff mnemonics had not been validated as effective for nursing shift reports. For example, SBAR is a situation briefing tool designed to communicate critical information between healthcare providers (HCPs) and

nurses that has been adapted as a handoff tool.[8] Since SBAR communications must be brief and concise, there is some concern that this format might give nurses the impression that communicating less information is preferred. As such, this tool was found to be inappropriate for change-of-shift handoffs.[4]

A study of the I-PASS tool (designed for HCP-to-HCP report) in nursing found limitations with this approach.[4] For example, illness severity (the I in the tool) was not useful in nurse handoffs because of the subjective nature of the term for nurses and its lack of connection to nurses' focus on care complexity.[4]

To address these problems, nurse-centric handoff tools have been developed, including the mnemonic N-PAS (Nurse, Patient summary, Action plan, and Synthesis) and the blueprint NURSEPASS, which was designed to guide the how, what, where, and preconditions for handoffs (see *Select tools for nurse handoffs*).[3,7] Regardless of the chosen tool or mnemonic, the content in the tool should be adapted for the unit's patient population, clinical setting, and context.[3,7] Special attention should be given to ensure the inclusion of critical elements such as allergies and resuscitation status to promote patient safety.

Select tools for nurse handoffs

Mnemonic: N-PAS[4,7]
Nurse (the identified tool is specific to nursing)
Patient Summary (15 areas: demographics, admitting diagnosis, mental status, code status, allergies, pertinent medical history, current vital signs, current labs, pertinent physical assessment, pertinent medications, pertinent family information, precautions, lines/drains/ tubes, ADL status, ambulatory status)
Action Plan (5 areas: Nursing interventions to consider, procedures/tests to do, discharge planning, nursing interventions to monitor, patient/family education)
Synthesis (allows sender and receiver to ask questions and clarify information)

Blueprint: NURSEPASS[3]
HOW: Nursing shift handover style
WHAT: Contents of structured handoff (adapted to unit and type of patients)

Name and identification of patient
- Name, date of birth, gender, allergies, resuscitation status, transmission-based precautions

UCare providers
- Attending HCP, surgeon, other caregivers

Reason for admittance
- Reason for admittance, relevant history, diagnosis, relevant comorbidities

Situation
- Relevant results of diagnostic studies and treatments (such as lab and radiology results)

Evaluation
- Vital parameters, pain

Plan
- Treatment plan, multidisciplinary treatment goals and evaluation, planned discharge date

Actions
- Assignments and tasks

Summary
- Summarize and verify information received

Safety check at the bedside
- (High-risk) medication, pumps, drains, catheters, and dressings

WHERE: Location for handoffs

PRECONDITIONS: An environment that supports the opportunity to ask questions and identifies nurses to act as role models and teachers of effective handoffs

Choosing the appropriate location

Handoffs should be conducted face-to-face, free of nonemergency interruptions in a consistent location with sufficient time allotted for this exchange of information with the opportunity to ask questions.[1] The sharing of confidential patient information requires a location that provides privacy.[3]

Nursing bedside shift reports (NBSR) that include the patient and family are recommended by the Agency for Healthcare Research and Quality (AHRQ).[9] Some nurses have been hesitant to adopt the bedside location, citing fears that it may take longer and concerns about confidentiality if patients are not in private rooms.[3] The evidence, however, supports the inclusion of patients in shift report. This practice has been shown to decrease staff overtime, increase patient and nurse satisfaction, enable the early assessment and direct visualization of the patient during report which reduces handoff errors, enhances patient

safety, and reduces adverse events.[5,10] Nurses who have tried NBSR felt they were more prepared to assume the care of their patients and appreciated that they were able to carry out a safety scan during the process.[5,11,12] Successful NBSR requires a flexible standardized reporting process to tailor it to individual patients; for example, to allow for a discussion of sensitive information outside the room to prevent harm to a patient who may have a terminal diagnosis.[5] Patients also need to be informed about this new process to make sure that the handoff is effective. AHRQ provides resources to support NBSR, including an adaptable patient and family education pamphlet, a shift report checklist, and training slides for nurse education.[9] The Inova Health System in Virginia developed the ISHAPED mnemonic (Introduce, Story, History, Assessment, Plan, Error prevention, and Dialogue) to guide the bedside report to be more patient- and family-centered and allow for the communication of potential safety concerns.[13]

Using effective communication

A shift report is a structured conversation between the sending nurse and receiving nurse. When expectations between the sender and receiver are misaligned, communication errors such as an inaccurate, incomplete, untimely, or misinterpreted transfer of critical patient information can occur.[1] Effective communication during handoffs is essential since miscommunication during this process has been linked to errors and patient harm. Streeter and Harrington[14] sought to understand the key communication behaviors in a competent handoff. They instructed nurses to describe their best and worst handoff communication experiences during information giving, information seeking, information verifying, and relational (socioemotional) behaviors. The authors concluded that a competent handoff involves the exchange of information and a focus on the nursing relationship.[14] Their findings are summarized in a handoff tip sheet that emphasizes what makes the best handoffs (including pertinent accurate patient information; encourage questions and answers), the role and responsibility of the outgoing nurses (such as organizing relevant patient information, facilitating positive patient relationship) and the incoming nurse (such as listening carefully; paying attention; and being respectful, appreciative, and supportive), and ways to build trust and rapport (for example, thank the outgoing nurse and withhold criticism of work undone).[14]

Considering nurses' right to work with a reliable process

Desmedt et al.[2] conducted a review of systematic reviews and found some evidence that standardized and written handoffs resulted in improved teamwork, greater accuracy and consistency of information transfer, a decrease in the number of forgotten tasks, improved patient and provider satisfaction, and saved nursing time. They caution that good-quality research on handoff designs and their outcomes is limited and better-designed studies are required. A quality improvement approach is recommended to implement and sustain a highly reliable and high-quality handoff process.[1]

To accomplish this goal requires that the process be monitored to ensure that it is practiced as designed. Changes in units are inevitable in a dynamic healthcare system. These can include new leadership, new nurses, and changing workload demands as experienced during the COVID-19 pandemic. Changes can increase the chance that nurses will drift into past, familiar handoff processes. Hardwiring the process through education, assigning coaches and champions, regularly auditing the process, and examining failures in handoffs that contributed to patient harm will ensure a greater chance of sustaining the right handoff process. Audit forms, such as those developed by Smeulers et al.[16] and published in supplementary files, can be used to evaluate the effectiveness of handoffs. Nurse satisfaction with the process and their perceptions on how it contributes to their ability to provide excellent care is also an important indicator to track.

Conclusion

A nurse-to-nurse handoff at shift change is a complex, high-risk communication process that is an essential component of safe patient care. As Florence Nightingale emphasized: "The very first requirement in a hospital is that it should do the sick no harm."[15] Ineffective handoffs have the potential to harm patients and need to be improved based on evidence. While there is no "one-size-fits-all" handoff tool, nurses need to advocate for the use of effective tools and procedures that meet the needs of their patient population. Nurses must also be supported and educated about effective handoffs to improve their

competence. Having a standardized handoff process with the appropriate preconditions, tools, environment, and communication strategies improves the continuity of care for patients, patient outcomes, and patient and nurse satisfaction. ■

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