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It was Friday morning, 0545, nursing students were eager on their first day of clinical to practice their new skills and use their new equipment. The night shift was finishing up their last charting and running off the reports for the night. Students were assigned in pairs to take vital signs and perform head to toe assessments. The students listened to report and then set out to perform their nursing care. Things were going smoothly until two students sought out their instructor because they were worried about a patient. They reported that their male patient age 76, was breathing “fast at 30” and his heart rate was “really fast” at 106. The instructor followed the students in to re-assess the patient. The findings were correct. The student’s re-checked vital signs, including saturations. Oxygen saturations were 81%. The instructor assessed his lungs, which were clear other than expiratory wheezes and rhonchi in his posterior bases. The patient was complaining that he felt like he was “being suffocated,” that he “couldn’t breathe.” He was using accessory muscles in his neck and intercostals, and was moving about in bed trying to find a position of relief. It was apparent to the instructor that something was going on. The patient’s nurse was notified about his breathing difficulty. Her immediate response was “They said in report that he has been doing that.” She showed little concern but at the instructor’s urgings, went into the patient’s room. Again she stated, “This is exactly what they said in report he had been doing. They gave him a pill and it helped him a lot.” She did no assessment, but left the room to see what the previous shift had given him. The instructor was not pacified. She sought out the respiratory therapist. He too had been given the report that this patient had been confused and had episodes of breathing fast. He reported that he had been in earlier and had given a treatment.” He stated that the patient had COPD and they “get anxious.” He went on to attribute
the episode to the fact that the students and the instructor were in the room. As the instructor was about to return to the room, the physician walked into the patient’s room and closed the door. About one minute later, he came out to the nurse’s station and stated, “What is wrong with my patient? He is huffing and puffing like a freight train.” He spoke with the nurse, who tried to explain what had been passed on in report. The doctor pointed at the chart, and wanted to be shown where the information was in the chart. Un-appeased, he gave orders for the patient to be moved into ICU immediately to rule out a P.E.

Definition

Handoff is defined as the act or an instance of passing something or the control of it from one person or agency to another (www.thefreedictionary.com). Dracup & Morris (2008) describe handoff as a term used to describe the role and responsibility from one person to another person (p. 95). In Nursing, other terminology used to identify handoff is handover, shift report, and shift-to-shift report.

Handoff is broadly defined because of the numerous situations that occur in the health care setting (Runy, 2008, p. 45). Whenever there is a transfer of responsibility for a patient from one caregiver to another, there is a handoff. The objective of a handoff is to provide relevant patient information to the receiving person, which will ensure safe, continuity of care. Handoff can occur when patients have a change in their location or provider (IHeal Handoff of Care: Frequently Asked Questions).

Four typical kinds of handoffs in health care are: (a) change in level of care such as inpatient admission from the emergency department, clinical, or procedure area, (b) temporary transfer of care from inpatient, clinical or emergency department to operating room, procedure area, diagnostic area, (c) discharge handoff occurs when there needs to be communication to the
next of care provider (if known) at inpatient discharge. Common sources would be home health, skilled nursing facilities, or possibly another hospital. This information can be via phone, fax, letter, or discharge summary, and (d) change in provider such as a registered nurse at change of shift, or rotation change of house staff. (IHeal).

Speas (2008) states change of shift report has been described as “one of the most powerful arenas of professional socialization and communication” (p. 235). She attributes its importance for promoting teamwork, retention of staff, along with quality of care (p. 235). Benson, Rippin-Sisler, Jabusch, & Keast (2007) defined shift-to-shift report as “an important information sharing process for ensuring and maintaining continuity and quality of safe patient care, It complies with legal and professional practice standards” (p. 81). Handoff is highly complex communication with a range of socially and technologically distributed practices and multiple functions (Kerr, 2002, p.131).

The most common form of handoff in nursing is the change of shift report. Change of shift report is a communication, which occurs between two shifts of nurses, where the purpose is thought specifically to be communicating information about patients under the nurses’ care (Lamond, 2000, p.794).

There are many methods to handoff including audio-taped report, verbal bedside report, report given face to face to an oncoming shift in a report room, report at the nurses station, and occasionally, report is given while sitting in chairs in the hallway. Home health nurses give report of their patients to the on-call night and weekend nurse. Skilled nursing facilities and assisted living facilities also use change of shift report approaches similar to the hospital.
Health care providers should use a standardized, consistent approach, to whichever method is used. One example of a standardized approach being implemented is SBAR. There are four components, which make up this template.

- **Situation** - details of the patient’s current situation.
- **Background** – information, which contains past history relevant to injury or illness, which is being treated.
- **Assessment** – current clinical condition.
- **Recommendation** – orders clarifying what needs to be done, test results to review, and items, which need MD notification.

SBAR is considered an important tool especially because it can be used when departments are crossed. Communication is structured and the person listening to the handoff knows what to expect. One of the first steps to implementation of SBAR is to teach the staff in order to ensure consistency in the performance (Richey, 2007, p. 3). There are other approaches being used to hand off which utilize the same principles. These approaches should also consist of an opportunity for the oncoming caregiver to ask questions.

Handoff should include vital, up-to-date information concerning the patient’s condition, along with any recent or anticipated concerns in the condition of the patient (Berkenstadt *et al*, 2008, p.159).

**Importance to Nursing**

The concept of handoff is important to nursing because it is the only way to communicate events, which occurred under the previous nurse’s watch. Benson *et al* (2007) propose that an accurate and efficient report is essential to good patient care because we are seeing higher patient acuity and higher staff turnover rates (p. 81). Patient safety is a major concern. Dracup & Morris
suggest that patients are more vulnerable when transfers of patient care from one person to another occur, because it is a time when valuable information might be omitted or confused. It especially puts critically ill patients at higher risk for errors to occur (p. 95).

Runy’s (2008) research pointed toward communication breakdowns being a leading cause of medical errors. She indicated that according to the Joint Commission, between 1995 and 2004, communication problems were the primary cause of 65 percent of sentinel events. In 2005, the percentage jumped to 70 percent, half of which occurred during handoffs (p. 44).

In the 2006 National Patient Safety Goal’s is a specific goal, which requires healthcare organizations to improve the effectiveness of communication among caregivers. Requirement 2E refers to hand-off communication based on a standardized approach. The method must be interactive and allow staff members the opportunity to ask and respond to questions. The requirement states: “Whatever the hospital’s policy, it should be followed by all staff members, and handoff communications should cover up-to-date information about the patient’s care, treatment, service, current condition, and any anticipated changes to that condition” (Catalano, 2008, p. 552). The expectation of this safety goal is to improve patient safety and continuity of care across the board (Adamski, 2007, p. 10).

Kerr (2002) identifies that Sherlock and Thurgood (1995) have also adopted the view that handover is defined by continuity of patient care (p.126). Handoff is a way to provide continuity of care in order to reach patient centered goals. Nurses and patients communicate and work together to achieve the goals related to the patients care. Handoff gives nurses the chance to communicate information about the patient.

Bedside handoff allows nurses face-to-face report. This type of handoff involves two nurses looking at the same things such as intravenous lines, wounds, monitors, etc., at the same
time (Richey, p. 3). It is a very thorough type of report, which allows patients to be involved in their plan of care so they know what it takes to meet their goals.

Handoff can also be a great resource for staff education as inexperienced nurses have the opportunity to observe proficient nurses. Speas contends that change of shift report not only promotes independence and teamwork, but also smoothes the transition of the beginner nurse into the professional as they observe the practice of a more experienced nurse (p. 236).

Handoff also provides the opportunity for nurses to debrief by discussing heartbreaking outcomes. Being able to discuss patients who have had long-term hospital care and experience a decline or die, allows nurses to offer support to one another through their communication.

There are numerous handover styles and functions, but Kerr concludes that the best option for handoff is dependent on the context (p. 126). Runy identified three keys to successful handoffs: “(a) Implement processes that clearly define the transfer of responsibility from one caregiver to another, (b) Standardize the process, and (c) Allow for an interactive exchange between the parties involved (p. 44). Utilizing this approach will ensure safe, continuity of care for patients.

**Application in practice Clinical-education/Research**

Handoff occurs in clinical practice at least two to three times a day, every day. Dowding’s (2001) research reveals that the role of shift report has been considered a “ritual” (p. 837).

The concept of handoff is the same for all nurses, but the process can be different in any given hospital. In one instance, the charge nurse can give report about all the patients. Another way is to have each nurse give individual report to the oncoming nurse, Report can also be given in a report room where each of the nurses give report to the entire oncoming staff.
should be done in a confidential place to enable nurses to discuss things that could otherwise be inappropriate to discuss in front of a patient or others.

Nurses can use a kardex or report sheet to help keep them organized in their report. They relate new orders, orders that have been discontinued, as well as information gleaned from doctor’s rounds. Report can include family dynamics and how they impact patient care, patient compliance, concerns which occurred during the shift, lab results, discharge plans, etc. All of the information that will ensure continuity and safe patient care should be exchanged at handoff.

There have been several concerns recognized with the process of report. Benson et al. identified their most common concern as the challenge to stay within a time limit. They attributed this to higher patient acuities, which require longer report, as well as sharing of extraneous information, which preoccupied the nurses with insignificant information (p. 81).

Other barriers identified were “inability to access the patient kardex, frequent interruptions, idle chatting, agency staff requiring additional information and/or time, staff believing that they had to justify what they had done on their shift, and the report being unclear” (p. 81).

Berkenstadt et al. also acknowledged major barriers. They identified the physical setting, including disruption from background noise and lack of privacy; the social and professional setting, such as stress of medical personnel at change of shift; issues involving the chain of command; barriers caused by language and culture; and the limitations of communications such as telephone, paper, and records which are computerized (p. 159).

Runy quotes Cheri Lattimer R.N. (executive director of the Case Management Society of America), in regards to the practice, “There is no one-size-fits-all process. The only common
denominator is the patient. To improve handoffs, patients should be involved whenever possible because they can be strong advocates in the care process” (p. 44).

The common theme of nursing shift reports is that it should improve the continuity and quality of nursing care as well as act in accordance with professional standards and legal requirements (Wilson, 2007, p. 201). This can be accomplished by developing frameworks, which meet the goals of the JCAHO requirements.

The concept of handoff has also been used to research other aspects related to the practice of nursing handoff. Communication seems to be the underlying focus of much of the research performed. Other research articles have been written to define handoff: Improving shift report by defining principles and guidelines, (Benson et al, 2007), Challenges of handoffs, (Dracup & Morris, 2008), Results of effects of handoff on staff, (Speas, 2008).

The most recent research has been focused on strategies and techniques to develop a standardized approach to fulfilling the requirements of the JCAHO national patient safety goals (Runy, 2008, Wilson, 2007, Adamski, 2007).

History of the concept

Do not take care to express yourself in a plain, easy manner, in well chosen, significant and decent terms...labouring as much as possible, not to leave them dark nor intricate, but clear and intelligible. -Miguel de Cervantes, preface to Don Quixote.

Kerr ‘s research shows that as early as 1969, Clair and Trussell defined handover as “the oral communication of pertinent information about patients” (p. 126). Lamond asserts that early practice recognized handoff as being vital for maintaining the continuity and quality of care. It did not however, address the role it plays in facilitating the information to plan care for the patient (p. 794).
Dracup & Morris acknowledge that attention to handoffs has only come within the past few years. They point out that even though change of shift report happened 2-3 times a day for years, it was a subject that was rarely discussed in nursing literature. They also note that it was “almost never discussed in the medical literature” (p. 95). Kerr concurs that handoff was not recognized in published work until recently. She does however, acknowledge that there have been researchers who have addressed the question and function of handover; while concerns of location and method, were examined by others (p.126).

Recent research has been directed towards the effect of communication on patient care. In her article, “An exploratory study of communication during shift report” Hays (2002) describes how the level and effectiveness of communication techniques were determined by factors such as the difference in the way report is given, nurse’s education, and time working at the facility, etc. The findings suggested that the shift report had the potential to affect not only quality of care, but also staff retention.

Odell (1996) explains how the communication process model is applied to the handover report. As the problems of communication are identified, recommendations for practice can be made according to which element (sender, message, receiver, and feedback) of the model is affected. Nursing skills and knowledge can be developed and applied to improve patient care.

In 2000, Lamond examined the role which handoff had on nurses’ ability to process information and plan care. The findings indicated that key features of a situation allow individuals to access appropriate knowledge within their long-term memory. This feature allows nurses to process information in shift report, which leads to more efficient care planning.
Kerr maintains that the effectiveness of handover includes time spent, as well as flexibility in multiple sometimes-conflicting functions. She concludes that the hidden expertise and knowledge used in handoffs could promote professionalism in nursing.

Dracup & Morris describe the parallel of concern of patient safety addressed from a nursing and medical point of view. They report that little attention is paid to handoffs in nursing and medical schools. Instead, training occurs as medical and nursing students watch their clinical preceptors give and receive handoffs. They conclude by stating it is time for students to know what they need to know to carry out safe handoffs, before they get to a clinical area. They also address the need for standardized formats to be agreed upon and used by hospitals.

Speas addresses the fact that nursing teams are mutually supportive but yet are critical of each other especially when following the work from the shift before. Pointing out the weaknesses or faults of others as a reason to make ourselves look better is used as an example. Showing consideration for our colleagues is mentioned as a “rare occurrence” (p. 235). Speas concludes that shift–to-shift report can improve communication, teamwork and patient care.

3-5 critical attributes that describes this concept

1. Effective communication
2. Forwarding of knowledge
3. Goal of providing patient safety and continuity of care
4. Teamwork
5. Confidentiality

How the concept is recognized assessed and or operationalized in professional practice and research? How do you know it when you see it? How is it measured?
Change of shift report is a vital part of patient care. It is expected to happen at the beginning of the new shift. Nurses can expect to have some kind of report no matter which hospital or health care setting they work in. Nurses convey information about the patients they have just cared for to an oncoming shift. Nurses adapt to whoever is giving the report and hopefully know to ask the questions which are not covered. Handoff is measured by the nurses, which are the participants. They utilize information communicated along with their knowledge, to provide the care to the patient. Handoff could be put on a continuum based on a short brief report to a lengthy in-depth report depending on patient acuity. Nurses can help patients meet their goals if accurate, pertinent, information is communicated.

The location and length of report also define handoff. The majority of handoffs take place in a room on the unit, nursing station or the staff conference room (which is preferred as the location for report because of confidentially reasons). However, the unit desk, patient’s bedside and hallway are also identified as locations where report is given. The report takes anywhere from 15-45 minutes on average to complete.

**Relevant Nursing theory**

A nursing theory that relates to this concept would be Imogene King’s theory of goal attainment. Her theory is based on the approach that a nurse interacts with a patient and they work together until the goals are met. For example, if the doctor gives an order for the patient to ambulate, the nurse and the patient will make a goal to ambulate four times in the hall by the end of the day. If the patient only ambulates twice during the morning shift, the nurse will need to notify the oncoming shift that the patient needs to ambulate two more times before the end of the day to meet her goal. If the nurse coming on shift is not made aware of the goal then she might not incorporate it into her plan of care. This omitted information might be the reason why the
patient is unable to meet her goal and progress with her recovery. Patients need encouragement and follow through to meet their goals.

The patient described in the introduction was not given a chance to make and attain his goals. There were several barriers that prevented him from receiving the care he needed. Information about his co-morbidities was omitted in the shift report. Inaccurate assumptions regarding his condition were passed on in report. His primary nurse did not perform an adequate nursing assessment, and was on the verge of administering a medication to “fix the problem”. Poor communication had progressed though several nursing shifts as well as to the respiratory therapy department. This situation also involved the student nurses who were very impressionable. This is a perfect example of how patient safety is jeopardized when nurses rely on inaccurate information passed on in report.

Describe how the concept relates to a nursing problem or specific population. What is the population and setting? What is the nurse’s role? How or why is this concept important to this population—describe relationships between the concept, patient population nursing practice and associated/related concepts.

The concept of handoff relates to all areas of nursing. Nurses take on a responsibility to provide safe, effective care for patients. Wilson reminds us that people die when information is missed (p. 201).

Nursing problems happen when errors occur as care is transferred. The population includes patients, which have the potential to be injured as a result of poor handoff. The possible settings are hospitals, home, skilled nursing facilities, assisted living facilities, urgent care and MD offices. The nurse’s role is to provide thorough, pertinent transfer of information, which will
ensure patient safety, and continuity of care. This concept is important for patient safety, effective patient care, staff development, staff education, and to promote professionalism.

**Conclusion**

Handoff is an important concept in nursing. Patient’s lives depend on nurses to utilize correct information in order to ensure safe, quality care. Nurses need to be aware of and avoid the concerns and barriers, which impede their ability to perform safe, effective patient care. Hospitals need to standardize the handoff approach according to the context. Staff needs to be in-serviced to ensure full implementation and consistent use. Patients deserve to receive the appropriate care that will help them reach their goals without fear of harm or death.
References


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