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The Use of a Standardized System of Communication to Change the Perception of Handoff Communication in a Psychiatric Setting

Alicia Renee' Plunkett
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Alicia Plunkett

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Allison Terry, Committee Chairperson, Health Services Faculty
Dr. Nancy Moss, Committee Member, Health Services Faculty
Dr. Phyllis Morgan, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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MSN, Walden University 2007

MSHA, University of St. Francis, 2005

BSN, University of Memphis, 1995

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The Joint Commission's review of sentinel events indicated that communication errors were the cause of over 65% of the sentinel events occurring in healthcare. The nursing profession has the responsibility of providing 24-hour care in an acute care setting and nurses are thus the primary participants in the handoff communication process. The purpose of this project was to assess the nursing staff's perception of handoff and to create a process for handoff communication. The most common framework for correcting communication errors in the literature is the Situation, Background, Assessment, and Recommendation framework, which was used as a guide for developing a process and form for handoff in this facility. The "Clinical Handover Staff Survey" developed by O'Connell, MacDonald, and Kelly (2008) was modified for use in this study. This survey was distributed to nurses and mental health technicians in 2 acute care units within a standalone acute care psychiatric hospital (n = 140). The quantitative survey identified 3 common barriers to the process in this facility that included: (a) interruptions, (b) subjective terminology used to describe patients, and (c) the lack of confidence in the information presented. After the implementation of a new process and form, the staff members were resurveyed to measure their post implementation perceptions of the handoff process. In each of the 3 areas measured, the implementation of a new process and form allowed the facility to see changes in the staffs' perceptions of the handoff process. The changes seen in this facility further indicate the need for education, standardization, and a continued focus on improving and mastering the important task of handoff communication. Improving handoff communication prevents errors in patient care from occurring, therefore decreasing mortality and morbidity rates.

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Dedication

I would like to dedicate this project to my mother Bernice Travis. As a little girl I idolized your career as a nurse; one that is respected by your peers, supervisors and patients. Having the opportunity to visit your job and see that respect fueled a desire in me to be the best nurse that I could be and hopefully one day live up to the giant foot prints you left for me in this field. I hope this makes you as proud of me as I am of you.

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To my husband Cedric Plunkett thanks for your patience and understanding of my desire for continued learning. To my three sons Christopher, Correy and Chaz always strive to be the best at what you do and know that you are already the best to me. Additionally, I would like to thank the staff of PBHS for their hard work in making this project a success. I would also like to thank Tina Edgett and Robyn Caldwell for their support and being great sounding boards when needed even as they completed their own educational endeavors.

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Section1: Introduction

In acute healthcare settings, the transfer of information and responsibility of care from one healthcare provider to another is part of communication that occurs daily. This form of communication is referred to as handoff communication, and is noted to be a process that encompasses many styles and opinions that can fluctuate depending on the facility, the shift, the unit and the nurse (Friensen, White, & Byers, 2008). This process can occur between many different disciplines providing care for any one patient or groups of patients and can occur at many different transitions of care. Handoff communication is considered to be a critical process to the continuity of care and treatment of patients (Friensen et.al, 2008). Because handoff communication is such a critical process, it is important to provide an environment that supports the process and educates nurses on the importance of the process.

In any healthcare setting, it is important for nurses to have an accurate understanding of both the benefits and downfalls of handoff communication and how each affects the care they provide. Handoff communication can be both positive (effective handoff) and negative (ineffective handoff) in healthcare. Positive or effective handoff communication has several benefits to the caregiver and the patient which include facilitating the communication of information that is succinct and relevant from one health care provider to another about a patient or group of patients. Effective handoff also strives to improve patient care directly or indirectly, increase safety, decrease repeated patient questioning as well as increasing patient satisfaction (Cleary, Walter, &

Horsfall, 2009). And finally, the most important benefits of effective communication include the reduction of errors, decreasing morbidity and mortality by ensuring that each clinician is given critical information needed to provide care to their patients.

Negative or ineffective handoff communication leads to incorrect treatments, delays in treatment, diagnosis, adverse events, patient complaints, increased lengths of stay, and increased healthcare expenditures (Cleary et.al, 2009). Ineffective handoff communication can also lead to potential legal risk for the clinician and the organization responsible for the patient. Improving handoff communication in healthcare has become not just a facility issue but a national healthcare issue and one that begs the need for immediate improvement.

Background

Effective communication among healthcare providers is imperative to ensure safe patient care (Klee, Latta, Davis-Kirsch & Pecchia, 2012). During the years of 1995-2005 the Joint Commission's review of sentinel events indicated that communication was the root cause of over 65% of the sentinel events occurring in the healthcare arena (Klee et.al, 2012). This data alone is a clear indication of the need to improve communication among healthcare providers. In order to understand and correct the problem of communication, there has to be clear definitions of the types of communication that can lead to errors in care.

Healthcare accrediting organizations such as the Joint Commission have identified the process of handoff communication as one of the major contributors to

missed opportunities in healthcare. Handoff communication is defined as the transfer of essential information and responsibility for care from one healthcare provider to another (Friensen et.al,2008).In nursing practice there are several different terminologies used to describe this process such as hand-over , sign-out , sign-over , cross-coverage and the most common being shift report (Friensen et.al,2008) . For the purpose of this project handoff communication will refer to the process of shift report which occurs as one shift leaves and another takes over the care of a patient or group of patients.

Handoff communication at the change of shift conceptually is a process that is designed to provide critical information about the patient, allow for exchange of information between the giver and receiver is often performed within complex organizational systems and cultures that impact patient safety (Friensen et.al, 2008). Many organizations recognize the significance of this process. In 2007 the Joint Commission Accreditation and Certification Organization (JCAHO) began to require that accredited facilities develop and standardize a protocol for nurse handoff communication. This standardization came in the form of a National Patient Safety Goal 2E (JCAHO 2012). According to Triplett & Schuveiller (2011) the main purpose of this goal is to ensure that accurate information about a patient's care, treatment, services, current condition, and any recent or anticipated changes is communicated during any handoffs that may occur. If nurses are given critical information about the patient or group of patient's they are assigned , it is expected that the nurse will be in a better position to provide guided safe and effective nursing care.

According to Friensen ,White ,and Byers (2008) , the development of a process that meets the intent of the National Patient Safety Goal developed by the Joint Commission in 2006 remains challenging for organizations in terms of developing and implementing effective strategies for handoff across various healthcare settings because of the complexity of healthcare delivery (Friensen et.al, 2008) . In the development of this National Patient Safety Goal, the Joint Commission suggested five key expectations for this goal which include:

1. Interactive Communication allowing for the opportunity to ask questions between the giver and receiver of information.
2. Communication of up to date information regarding a patient's care, treatment, services, condition and any recent or anticipated changes.
3. A process that allows for verification of information received.
4. A process that provides opportunity for review of relevant historical data about the patient.
5. A process that limits interruptions.

Even with the development of the National Patient Safety goal that addresses communication, there is still a gap in the practice and goal of ensuring handoff communication is accomplished in many practice settings. This gap is related to many factors and is often cited to include factors such as the complexity of healthcare organizations, increased acuity of patients , increases in the number of clinicians involved in patient care , the development of many different specialty areas of care , technological advances in care and the expanding knowledge of healthcare (Friensen et.al , 2008).

Problem Statement

There is a difference in the information communicated during handoff when units within one facility are allowed to use several different methods of communicating information such as tape recorders, dry erase boards, bed boards with staff dictated information as report sheets and or unstructured free verbal communication. Patient care errors can result from this lack of a standardized handoff communication tool and process. This unstructured process can often lead to a common problem in psychiatric facilities which is the use of social judgments during handoff communication that are not relevant to patient care (Priest & Holmberg, 2000).

One common depiction of this process would occur as follows: a patient who is admitted to the acute psychiatric unit during the day shift. The nurse completes a comprehensive nursing assessment on the patient that occurs through an interview process. The information gathered during this interview is passed on to the admitting physician for patient care orders. The orders are transferred to the medication administration records and the treatment plan. Some of the information is written on a communication board located in the back of the nursing station, while other information is handwritten on a pre-printed bed board.

The admitting nurse decides what information is passed on to the next shift versus what information is written on the communication board. During the process of the evening shift report, the nurse gives the patients name, age of the patient, the admitting diagnosis, no history and states the patient has been very manipulative and demanding. And finally the nurse states, “by the way, the patient is a big thuggish looking guy”. The

lack of continuity in the required information to pass on leaves it to the discretion of the admitting nurse to determine what is important and relevant to communicate to the next shift. Based on interviews and the results of the Handoff Communication Survey in this facility there is a definite lack of consistency and staff feel information is often omitted that would allow them to better provide safe care to patients on the unit.

The information communicated during the handoff process is a starting point for each nurse's prioritization of steps in the care of a patient or group of patients. This information further formulates the first opinion of the nurse in providing care to the patient. The use of labeling is often a fallacy that leads to poor development of a therapeutic relationship between the new staff and the patient. In a psychiatric nursing setting the inability to form a therapeutic relationship with the patient can hinder the care given and received by the patient. Terms such as "attention seeking" "malingering", "dangerous" can impede the development of a therapeutic relationship with the patient. An alternative to the use of labeling terms would be an actual description of specific behaviors exhibited by the patient on the unit. By describing behaviors the nurse provides the staff with critical information that will assist them in knowing what potential and actual behaviors to monitor a patient for.

In this psychiatric setting the process of handoff communication often occurs at the change of shift for nursing staff and at any time there is a change in the supervision of a patient such as relief for meal breaks and the rotation of staff covering patients on a one to one basis. There are often several interruptions to the process of handoff communication in this facility. The interruptions occur in several ways which include

phone calls, doctors rounding, staff arriving late to the unit, admissions to the unit and staff being pulled to other units. These interruptions cause a delay in the process and further devalue the overall importance of the process. During the pre-implementation stage of the this project interruptions was identified as a major flaw in the process of handoff in this facility.

Because handoff communication is a high-risk process, when it is incorrectly completed or not completed at all it can lead to ineffective delivery of care and patient safety breaches (Freitag & Carroll, 2011). In 2002, The Joint Commission Accreditation and Certification Organization established its National Patient Safety Goals (NPSGs) program. The NPSGs were developed to assist accredited organizations in addressing specific areas of concern in regards to patient safety. Handoff Communication is one of the National Patient Safety Goals developed to aid in the prevention of errors in patient care related to not properly passing on critical information.The Joint Commission Center for Transforming Healthcare developed a set of solutions to address the problem of failed handoffs in care. The Center worked with ten hospitals to systematically identify pitfalls to handoff communication and work to address them. They found that barriers to successful handoffs include: incomplete information, lack of opportunity for discussion, delays, and lack of time. The Joint Commission Center used the application of process improvement which led to the opinions that in order for hospitals to implement a handoff communication process, they should use the SHARE principal (developed by the JACHO 2011) which stands for:

a. Standardize critical content

b. Hardwire new methods into the system
c. Allow opportunity to ask questions
d. Reinforce quality and measurement
e. Educate and coach

Purpose Statement

The purpose of this proposal was to improve the process of handoff communication in a psychiatric setting by developing a process and tool that encouraged the elimination of labeling terminology used in describing patients, increasing the staff's confidence in the information communicated and decreasing interruptions to the process of handoff communication. The significance of handoff communication was established through examination of archival data, implementation of a standardized process and recollection of data as a source of an outcome variable measurement. The objectives of this proposal are:

1. To implement a standardized handoff communication process and tool using the SHARE principles identified by the Joint Commission as well as components of the process of SBAR as a communication guide.
2. To increase patient safety as a result of pertinent and non-subjective clinical information being communicated among nursing staff.
3. To foster a culture that respects and understands the significance of handoff communication as evidenced by a decrease in interruptions of the process.

The handoff communication process has been described as the "Bermuda Triangle" according to White (2008).Handoff communication is a process that has significant impact on the continuity of care and the potential to cause or lead to significant errors in the care of patients. The decision to determine what information needs to be passed on, the time to pass the information on, the amount of information that needs to be passed are all key concerns of many regulatory healthcare organization and healthcare leaders around the world (White, 2008). There is limited research on how the process works in the psychiatric nursing setting.

Project Question:

Will the implementation of a standardized handoff communication tool and process improve handoff communication in an acute care psychiatric setting?

Causes of Failed Handoff:

With the fast pace of health care today, nurse handoff communication is a process that can be easily flawed. Some of the flaws identified include ; staff's lack of understanding of the process, unstructured end of shift nurse to nurse reports which result in inconsistencies including extraneous information, lack of clarity, incorrect information, minimal focus on plan of care, interruptions in the process, not enough time to ask questions and technology and information overload (Maxson ,Derby, Wrobleski, &Foss, 2012). A lack of understanding about the process of NHC is believed to be derived from the facilities having inconsistent policies and practices that address the issue. This lack of some kind of guide allows nursing staff to interpret the policy and decide based on personal experience and practice what information is considered important to pass on.

This practice can lead to significant errors in communication which can lead to errors in patient safety and continuity of care.

Unstructured end of shift nurse to nurse reports which results in inconsistencies including extraneous information, lack of clarity, incorrect information, and minimal focus on plan of care is another contributing factor to failed handoff communication (Triplett & Schuveiller, 2011).Having no structure to the process of providing information leads to the inability of the handoff process to be ineffective and prevents a required element which is to pass on critical information. When the process is not scheduled at a regular and consistent time with a set criterion for what information is passed on often, the result is a process that is haphazard and without meaning to the giver and receivers of the information (Triplett & Schuveiller, 2011). Another component of unstructured handoff process is one in which interruptions occur or there is not ability to ask questions about the information received. Interruptions can cause critical information to be forgotten and the process to be rushed as a result of time allotted to complete the process. Interruptions also cause information to be loss between the giver and receiver. For handoff to be productive, caregivers must be able to ask questions about the information received. If there is not opportunity to clarify what is heard then the process is hindered and information can be received incorrectly which leads to errors in care.

The final contributor to failed handoff communication process is technology and information overload according to Popovich (2012).Technology is designed to increase the ability for clinicians to provide care in a safer and more effective manner. It is also designed to ensure that information can be shared in the care of the patient. Technology

has also been identified as a process that has hindered the handoff communication process in that as it is implemented it becomes more of a focus instead of talking to caregivers in the relaying of information. Having the ability to pass on critical information in a snap shot allows the caregiver to provide effective care to the patients without having to search for the information. Because patients have become increasingly more acutely ill today, there is more information and additional decisions that guide their treatment (Freitag & Carroll, 2011). Caregivers have to be able to assess and identify changes in patient's conditions and be able to incorporate this critical information into their handoff process. It is this critical thinking skill that is needed for caregivers to be able to sort, identify and prioritize critical information. Information overload can often lead to failure to pass on critical information that will result is errors in patient care and impede continuity. Without the ability to critically think and sort information handoff communication is often flawed.

Significance to Practice and Social Change

During the years of 1995-2005 there were reported more than 4800 sentinel events analyzed by the JACHO with communication identified as the top contributing factor to medical errors (Triplett & Schuveiller, 2011). The most significant contributing communication issue identified was the handoff communication process. This process accounted for more than 80% of the more serious preventable errors ((Triplett & Schuveiller, 2011). In a report by the Institute of Medicine (IOM) an unprecedented number of incidents that were considered to be preventable errors in the United States all of which were linked to failed communication (Popovich, 2011). As a result of these

errors, the IOM Committee on the Quality of Healthcare in America bought national attention to the need to improve the safety of patients in the healthcare setting. As a result of this call for increased safety in healthcare settings, the Joint Commissions Sentinel Event Advisory Group proposed the implementation of the National Patient Safety Goals. In 2011, the goals were revised and Goal 2 focuses on communication that is timely, accurate, and completely unambiguous and understood by the recipient (Popovich, 2011).

The issue of NHC has been addressed in the literature through a number of research projects where nursing leaders and educators have attempted to identify ways to meet the intent of the Joint Commission's National Patient Safety Goal of Improving Communication (Friensen , White, & Byers, 2008). Each of the research projects has attempted to identify a standardized process for many different clinical settings such as acute medical facilities, pediatric units and emergency rooms. However there is limited research available on how to best implement a process of handoff communication in a psychiatric setting. Even though a plethora of research has been conducted and many authors describe ways of implementing standardized processes of handoff communication, there are many articles that address the need for more research. Approximately 45% of the hospitals surveyed determined that there is room for improvement in the area of handoff communication(ED Management, 2007).

Definition of Terms

For the purpose of this study, the following operational definitions will be used:

Handoff Communication Process is the transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include the opportunity to ask questions, clarify and confirm. In this facility, this process is often referred as shift report (Friensen et al., 2008).

Joint Commission (Joint Commission Accreditation and Certification Organization) is an independent, not for profit organization. This agency accredits more than 20,000 healthcare organizations and programs in the United States (Joint Commission, 2012).

National Patient Safety Goal (NPSG) is the process by which the Joint Commission identifies high risk process that can lead to patient care errors. The goals are used to assist accredited organizations in addressing specific concerns in patient safety (Joint Commission, 2012).

Institute of Medicine Committee on Quality of Healthcare in America- provides information concerning health and science policy and makes recommendation based on research for improvements in healthcare to policy makers and healthcare leaders (ED Management, 2007).

World Health Organization (WHO) is a specialized agency of the United Nations that is concerned with international public health. The agency monitors disease

outbreaks, and assesses performance of health systems around the globe (Brebner et al., 2011)

Agency for Healthcare Research and Quality (AHRQ) has as its goal to improve the quality, safety, efficiency and effectiveness of healthcare for all Americans. This translates research into better patient care and provides policy makers and healthcare leaders with information needed to make critical health care decisions (ED Management, 2007).

SHARE is the set of principals identified by the Joint Commission as the process facilities should use to standardize or implement a handoff communication process , which includes , standardize critical content , hardwire new methods into the system , allow opportunities to ask questions , reinforce quality and measurement, and educate /coach (Joint Commission, 2012).

SBAR (Situation, Background, Assessment and Recommendation) is the acronym for a communication strategy used to standardize the way information is relayed between caregivers (ED Management, 2007)

Core staff refers to full time Registered Nurses, Licensed Practical Nurses and Mental Health Technicians working on the patient care units (E.Permenter personal communication July 15, 2013)

PRN staff refers to staff that work at the facility as needed based on patient volume or acuity (E.Permenter personal communication July 15, 2013)

Mental Health Technicians (MHT) are the staff that assist the nurses in providing care to the patients in this facility, They are the staff responsible for monitoring and maintaining safety of the patients in the milieu(E.Permenter personal communication July 15, 2013)

Assumptions of the Project

The following assumptions are made for the purpose of this proposal:

1. A Standardized communication process will improve handoff communication and lead to increased confidence in the information during handoff communication.
2. A standardized communication tool will increase accountability for information passed on at transitions in care.
3. Psychiatric nurses in the facility will openly discuss improvement or lack of improvements with use of new process and tool.
4. Psychiatric nurses will recognize the importance of utilizing a standardized handoff communication tool.

Limitations of the Project

The limitations of this proposal include the following:

1. Ensuring that all staff (both core and prn staff) working in the facility are trained to the new process of handoff communication and the tool is used.
2. The ability to get all (both core and prn staff) to complete the post implementation surveys.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Literature Search

The following online databases were searched using the Walden University online library: CINAHL (Nursing and Allied Health Literature); MEDLINE with Full Text and combination of CINAHL and MEDLINE were used. Additional reference lists from included studies were searched for more relevant studies. The key terms used in the search included Handoff Communication, Shift Reports, Communication, Clinical Handover, Nursing, Patient Safety and Mental Health Nursing Shift Report. The researcher limited the search of peer reviewed articles written within the last ten years and only those articles where full text was available. Articles of research as well as articles on the implementation of standardized handoff communications tools and processes were used in completion of this project. The initial search of electronic databases identified 755 citations. Citations with only abstracts were eliminated immediately from the search. Full text articles that focused on communication between other disciplines within healthcare were also eliminated as the project focus is on nursing

handoff communication. A exception for three peer-reviewed articles greater than the ten year requirement was made because the article were the only ones found that actually addressed the handoff communication process in a psychiatric facility.

Background

As far back as the 1880's the thought process behind the handoff communication can be traced to the medical model (Kerr, Lu, McKinlay, & Fuller, 2011). It is believed that physicians would make rounds with the night shift nurses and pass of orders for care. The Ward Sister would receive the information and pass onto to individual nurses information about the care of their patients for the next day. In recent times, the process of handoff communication has been referred to as a ritual that implies a tasks performed without thinking about it in a problem solving way nor with consideration to the information that needs to be passed on to ensure the safety of the patient. It is this practice that is believed to have led to the frequency of errors that occur at the time of handoff of responsibility of care from one caregiver to another.

Calls for Change:

Ineffective communication is the most frequently cited cause for sentinel events in the United States (Kerr et al., 2011). Nursing handoff communication has been identified as an ongoing problem with a large potential for risk to patient safety and has therefore become a huge clinical priority in many facilities and a focus of many healthcare regulatory agencies (Street et., 2011). In 2007, the Joint Commission developed the first National Patient Safety Goal that addressed the issue of enhancing communication in healthcare as a method of preventing patient care errors. Five years

later The Joint Commission continues to re-define the National Patient Safety Goal that focuses on communication as a priority for healthcare organizations. In 2012, the National Patient Safety Goal on communication now focuses on many aspects of communication including specific handoff communication between transitions of care from one caregiver to another (Joint Commission, 2012).The Joint Commission in its review of sentinel events has also recommended the use of a standardized process for communicating information (Joint Commission, 2012).

The World Health Organization has also recommended and been a supporter of the need to develop a structured handoff process. This recommendation is based on the belief that only 2.5% of information is retained using verbal handoff process. But with the use of note taking 85.5% is retained and 99% with a formal structured printed handoff process (Brebner, Sandhu, Addison, & Kapadia, 2011). The increase in retention of information is believed to be critical in ensuring safety of the patient from caregiver to caregiver and in time of crisis.

The Agency for Healthcare Research and Quality (AHRQ) has also called for formalization of a process during handoff communication that can assist in the reduction of errors at this critical time in patient care process(ED Management, 2007).This agency went so far as to recommend the use of the Situation, Background, Assessment, and Recommendation (SBAR) method of hand off across healthcare organizations. It is believed that this template will provide a process that is easily understood and can cross all areas of specialty within the nursing profession, thus aiding in reduction of errors through consistency and teach ability (ED Management, 2007).

Suggested Improvement Methods

According to Steinberger & Kirschbaum (2009) the prevalence of communication failures in health care results not only from the sheer volume of information exchanged but also from the many ways that communication channels can be disrupted and information mishandled. Although a lack of information may result in errors from uninformed actions, the problem in today's data-rich, technological environments becomes one of having too much information. The burden then becomes sifting through the less-critical irrelevant or bloated information to find—and then interpret—relevant information, generally while within a time-pressured context. The resulting "cognitive overload" adversely affects decision making and distorts situational awareness.

There are several research articles written that address ways of improving the issue of handoff communication (Triplett & Schuveiller, 2011). Many of the articles written suggest the need to implement a standardized process of accomplishing this goal .The most identified method of addressing this problem has been through the process of using the SBAR (Situation, Background, Assessment and Recommendation) process. SBAR was developed by the Kaiser Permanente in Oakland, CA and provides clinicians with a framework for communicating effectively about a patient's condition and needs (Healthcare Risk Management, 2007). It is believed that SBAR helps clinicians overcome a key cause of errors at patient handoff; the difference in how doctors and nurses communicate. Nurses frame communication in the form of holistic nursing care whereas physicians target the specific patient problem.

SBAR provides the communicator with key elements that outline what should be passed on at the time of handoff communication. The "S" stands for Situation which allows the communicator to tell the listener what the nature of the communication at the time. "B" stands for Background which provides information about the patient's history, usually designed to tell why the patient is in the hospital or clinic setting. The "A" is assessment and allows the communicator to tell what is they see that caused the need to pass on information. And finally the "R" is recommendation which provides the communicator the opportunity to suggest a solution to the problem the patient is having at the time.

In recent research it has been suggested that the completion of a bed side nurse to nurse report at the change of each shift is yet another solution to the improvement of communication at critical handoff times. The benefits of beside hand off communication according to Triplett & Schuveiller (2011) include the ability to prioritize care, enhance the relationship between the nurses, and increases accountability for the patient's condition, thus allowing opportunity for education related to new meds or equipment and other practices. Bedside handoff also allows for patient involvement in their care.

Researchers now suggest a third method of successfully addressing the issue of handoff communication which involves the development of a standardized handoff communication report sheet (HealthCare Risk Management, 2007). A standardized NHC form allows for consistency between shifts and ensures that critically identified information is always communicated. A standardized handoff communication increases accountability of nurses to know the patient information and to be able to speak to it if

questions were asked. The use of a standardized handoff communication tools according to ED Management (2007) has increased the safety of patients during critical handoff times because it provides a guide to ensure that certain critical information is communicated.

Frameworks and Theory

Therapeutic Relationship

Shift report is the beginning of the relationship building process for the nurse and her patient. In this process the nurse begins to gather a foundation for the beginning of nursing interventions and interactions that guide the patient's care. Hildegard Peplau's theory of Interpersonal Relationships is classified as one of the two leading theories in the Interactive Model of theories. Interactive models emphasize the need to develop relationships between the nurse and the patient (Parker, 2001). The theory focuses on identifying any interpersonal problems and providing intervention techniques that promote optimal socialization. The three stages of relationship building; orientation, exploitation and termination were critical to facilitate the process of healing in the mental health arena (Parker, 2001). Orientation occurs when the nurse and patient first make contact. During this stage, the nurse introduces herself/himself, gives a brief introduction as to his/her purpose and role and then proceeds to obtain the necessary information needed from the patient to begin care. During the second stage the nurse provides physical care, educates the patient about their illness and what can be done to promote optimal health and provides support or counseling for the patient. In the termination final

stage, the patient is discharged with a discharge plan and the relationship is terminated with closure for the patient (Parker, 2001).

In mental health nursing the need to successfully develop a therapeutic relationship with patients is critical to the success of the patient's treatment. Nursing staff must have the ability to develop relationships and this task can often be affected by the information passed on to the staff during shift reports. Each nurse during handoff has to have an understanding of the power of their message and how the words spoken can influence the ability of staff to facilitate the development of interpersonal relationships with patients in the psychiatric setting. Subjective labeling of patients in a psychiatric setting can often hinder the ability to provide care as well as form relationships with co-workers on a unit where team work is needed to maintain safety (Dean, 2009).Priest and Holmberg (2000) describe the implications of handoff communication on the care of the patient. When staff use descriptions that judge or label patients the staff inadvertently affect the ability of other staff to provide care to the patient that is based on objective data gathered from the assessment of the patient.

Situation, Background, Assessment and Recommendation (SBAR)

SBAR is the most common framework identified in the literature as an evidenced based method of correcting the issue of communication in healthcare. The Arizona Hospital and Healthcare Association (2007) stated that most communication challenges in life do not result in life and death situations; however in healthcare every conversation has that potential. Poor communication in healthcare is costly both financially and emotionally for the patients, their families and healthcare providers alike. According to

the Arizona Hospital and Healthcare Association Patient Safety Steering Committee in their efforts to address this issue completed research that lead to the recommendation that incorporating SBAR among all healthcare providers will make a significant and positive impact on the communication between healthcare providers , which ultimately will impact patient safety(Arizona Hospital and Healthcare Association, 2007).

SBAR's origin is from the United States Navy nuclear submarine program. Because of its success in the military, many researchers have studied its impact and framework for use in the healthcare arena. It is believed that SBAR creates a shared mental model for effective communication of information from one healthcare provider to another (Arizona Hospital and Healthcare Association , 2007) SBAR provides a distinct framework for communication of information which is delineated by its initials of S is the situation to be communicated, B is the background of the information , A is the assessment of what the problems is or information to be communicated and R is the recommendation to correct the problem(Arizona Hospital and Healthcare Association , 2007).Using this model will allow healthcare providers to communicate in ways that are effective and meaningful. These acts then create an environment that leads to reduction in errors, increased satisfaction for providers and better outcomes for patients and their families.

This model of communication can be tied to the development of a process within this psychiatric arena that will foster better communication. Using the SBAR framework for this facility will provide a structure for handoff communication process. The model will eliminate the use of subjective terminology to describe patients by providing nurses

with a format of expected information communicated; it forces the communicator to describe the situation or presentation of the patient , the patient's history , an assessment of the patient as well as what the nurse believes has worked for the patient or what could work. While providing clear distinct guides for information communicated, the SBAR process will potentially increase the confidence of the information communicated. It is believe that standardization of information improves the communication which leads to decreased negative outcomes and an increased teamwork approach to care. Having a process that guides the communication could also prevent lags in the presentation of information which often lends itself to interruptions.

Section 3: Methodology

Project Design and Methods

Quantitative research is concerned with the patterns that are unique to a population of patients, and can be particularly useful for investigating the effectiveness of an intervention (Terry, 2012). Quantitative research allows the establishment of a correlation and casual relationship between variables (Terry, 2012). Secondary analysis is a form of quantitative research that involves the use of data gathered in a previous study by another researcher or organization (Polit & Beck, 2002). Researchers often use secondary analysis of existing data because it is efficient and economical. Because of these attributes secondary analysis of data decreases the most time consuming and expensive part of a research project which is data collection (Polit & Beck, 2002). According to Polit & Beck (2002) the use of available data makes it possible to cut down time consuming and costly steps in research process, but with noteworthy disadvantages such as the researchers' inability to play a role in the collection of the data which can lead to deficiencies in data such as sample size , samples used and variables measured.

After completion of a staff engagement survey collection, the facility identified communication as a barrier in the facility based on scores from the staff. The facility also through its process of reviewing unwanted patient care incidents identified communication as the fundamental root cause of errors that have occurred within the facility. Staff identified failed communication as a reason for missed nursing interventions and failed completion of physician orders within the units. Several months later in an attempt to correct the communication that occurs within the nursing

department, the nursing leaders of the facility with approval of the Quality Council took on the project of improving nursing handoff communication. The first phase of the project included the use of a cross-sectional survey that involved all nurses and mental health technicians in the facility. The staff received a Clinical Handover Survey that was amended to fit the specific population of patients cared for and the practice of psychiatric nursing. The attempt by the facility was to gauge the areas of improvement that is needed and to determine the staff's overall willingness to change. This data became the foundation of further assessing the need and implementation of a project design to improve NHC.

The use of archival data has definite advantages and therefore is beneficial for completion of this project. The advantage of a secondary analysis of archival data includes by passing time consuming and costly steps in the process. Cross-sectional surveys enhance the ability to be able to research large numbers of people quickly (Terry, 2012).

Population and Sampling

The population of this project will be nurses working on two twenty-two bed psychiatric units in an acute psychiatric hospital. There will be a total of 60 potential nurses and a total of 80 mental health technicians that can potentially provide care to patients on these two units. These staff numbers include the potential prn staff that could work the units during the implementation of this project. The units operate 24 hours a day, seven days a week. There are a total of two shifts for the registered nurses 7a-7p and 7p-7a and three shifts a day for Mental Health Technicians which include 7a-3pm , 3p-

11pm & 11p-7am, where the opportunity for handoff communication can occur. Demographic data for nurses is shown in Table 1. The largest populations of nurses were female (92%), duration of employment ranged from 3months to 25 years (mean 6.1 years) and 72 % of the nurses were full-time employees. The nurses experience level averaged to 6.2 years of general nursing and an average of 10.6 years of psychiatric nursing experience. The largest population of Mental Health Technicians was males (53%), duration of employment 2 months to 14 years (mean 2.7 years) and 57% were full-time employees. Demographic data for MHT's shown in Table 2.

Instruments

After receiving written permission, the "Clinical Handover Staff Survey" developed by O'Connell, MacDonald, and Kelly (2008) was modified for use in this study by the facility (Appendix A) .Statements were modified to include a psychiatric nursing focus and to reflect the past tense. The inclusion of information specific to psychiatric nursing was important to gauge the ability of nurses without a psychiatric nursing background to identify the critical psychiatric information that is needed from shift to shift in order to provide safe care of patients on these units. The ability to gauge nurses' ability to identify critical psychiatric information for handoff will also provide nursing leaders with needed data to support increase education for nurses hired in the facility with limited psychiatric nursing experience. The change of statements to the past tense will allow comparison of the process as it is now and the process after implementation of the new standardized handoff communication tool. Nurses were provided information about the survey in several staff meetings. Staff was instructed that

they would be able to complete surveys anonymously if they felt more comfortable with that process. All surveys were expected to be returned within 30 days of being placed on the units. All surveys were to be placed in a designated mailbox in the facilities mail room and all staff had the option of completing a survey. There was several staff that chose not to complete the surveys as evidenced by the low completion rates of 52% of the staff completing surveys.

Data Collection

The process of data collection in this project began with the administration of the PBHS Handoff Communication Survey in the fall of 2012. This survey provided to all Registered Nurses and Licensed Practical Nurses employed by the facility both core and prn. The Mental Health Technicians were also administered the survey as extensions of the nurses and the staff who in the psychiatric arena spend the greatest amount of time with the patients in the milieu. Because of the role of the MHT, they often have valuable information about a patients feelings and progress in treatment. Data collection in this project also included direct observations in order to gather information about the styles and attitudes of the staff about the handoff process through observations of actual handoff opportunities over several shifts by nursing leaders within the facility. At the time of this initial attempt to improve the process, staffs were also allowed to write suggestions for improvement and subjective information about the process of NHC based on their personal experiences.

Data analysis and Project Evaluation Plan

Many organizations continue to struggle with the implementing a handoff communication process and tool that has been proven to be effective in providing a solution to this problem; which is to ensure that critical information is passed on at each handoff opportunity in the healthcare arena. In researching this issue there were several recommendations suggested for improving this critical task of the nurse, yet there was a minute amount of research found that provided a mechanism for improvements in the psychiatric nursing setting.

The first step in the analysis of data in this project began with the archival data of the Handoff Communication Survey conducted by the nursing leadership in 2012. The 21 question survey used to measure responses to perceptions of the handoff process and information obtained during the current process of handoff communication in the facility. The survey was based on a 5 point Likert scale rating from (5) strongly agree to (1) strongly disagree. A percentage was assigned to each question based on the total number of selections by each respondent compared to the total number of respondents completing surveys. The percentages were then used to determine the areas of concern by the staff and the areas of focus for the next stage which is the development of a standardized handoff communication tool. Based on this archival data 82% of the staff completing the surveys voiced a desire to see changes in the current handoff communication process. The data also revealed three main areas of concern which included: 45% of the respondents felt that the information provided during handoff were subjective, 33% of the staff felt that handoff was often interrupted and 47% of the respondents felt that the

information given to them during handoff communication was not relevant to patient care. This archival data provided the foundation for the development of this project.

The second step in the project was to obtain written approval from the facilities Quality Council which is led by the Chief Operating Officer of the facility, as well as the approval of the Walden University Institute Research Board (IRB) After receiving approval from both of these entities the process of data collection began. A consent form was also developed and provided to the staff to assist them in understanding that this was a voluntary process and that completion of the survey indicated permission to use their survey in this project.

The third step in the analysis of this project occurred after the implementation of a standardized handoff communication tool. A Post Implementation Handoff Communication Survey was administered to the same potential respondents and a comparative analysis occurred to determine the effectiveness of this process. The copulation of this information and the data gathered from the post survey will assisted in determining the effectiveness of this tool in increasing patient care outcomes by improving the relevance of information communicated, elimination of interruptions to the process and elimination of subjective information being communicated during shift report all of which hinders care and the development of therapeutic relationships within the psychiatric setting.

The objective of this project was to improve the process of handoff communication in a psychiatric setting by developing a process and tool that encouraged the elimination of labeling terminology used in describing patients, increasing the staff's

confidence in the information communicated and decreasing interruptions to the process of handoff communication. The process implemented included the standardization of critical content through a form that allowed for the communication of the same core information about each patient at every handoff opportunity. Because the form was designed to guide the nurse in giving certain background information each shift this would ensure that nurses working split days or weekends would receive the same information about the patient regardless of when they worked. This element also provides the (S) Situation and (B) background component of SBAR which includes the communication of why the patient is in treatment (which gives background) and any behaviors exhibited daily at each handoff opportunity (which gives situation). The form was also designed to allow the nurse the opportunity to pass on information about the patient's progress in treatment and any changes in the treatment that occurred during the shift either through doctors' orders or nursing interventions. These significant elements assisted in providing a voice for the nurse to communicate the (A) Assessment and (R) recommendation of patient care each day after the completion of his/her shifts. This information is the cornerstone of the nurse's ability to provide and make recommendations for quality care and prevention of errors in patient care. It is this information from the SBAR format that adds to the ability to provide continuity of care from one shift to the next in a psychiatric environment by communicating what has and has not worked for that particular patient.

The process of allowing for set times for handoff communication to occur at the change of shift and a pre-determined format was thought to aid in the (H) of the SHARE

which is to hardwire new methods into the system, however in many of the shift reports and post surveys there is still opportunity for improvement in this area as many of the nurses and mental health technicians have continued to enter shift report late and or leave early without receiving all information needed which hinders the opportunity to ask questions and seek clarification about the needs of certain patients. The final elements of the SHARE principle is to reinforce (R) and educate (E); which continues to occur by the leadership teams message to the staff that this process is critical to the safety of patients and designed education on handoff communication that is now a part of the facilities orientation of all new staff as well as the annual education of the staff as well.

Statistical Analysis

In the process of performing secondary analysis of data it is important that the researcher first determine the research question, identify the data needs, identify, locate and gain access to the appropriate parts of the data needed for their particular research project. The analysis of secondary data can occur in a number of ways such as the study of variables and relationships among variables that were previously unanalyzed (Polit & Beck, 2002). Polit &Beck (2002) point out that it is important to change the position of the variables in secondary analysis (e.g., a dependent variable in the original study could become the independent variable in the secondary analysis).

In this project, the researcher conducted a secondary analysis of data collected from the facility during a quality improvement project completed by the nursing leadership of the facility. The cross-sectional survey on the process of handoff communication within the nursing department was completed to gage the nursing staff's

perception of the process and identify key elements that needed to be changed within the facility to enhance the process. After the data was collected there was much resistance to change in the process which left the leaders at a standstill as to how to use the data to benefit the project and make improvements.

Because the survey represented a large majority of the nursing staff in the facility the researcher used all surveys as a beginning to the development of this project and its focus of improving the nursing staff perception of the handoff process in this facility. The first purpose of the data collection was to determine the staff's perception of the handoff process overall and determine if the staff felt that change was needed in the current process. The secondary analysis of the surveys conducted was to determine which elements of the process needed the most improvement and focus on those elements as a part of this project.

Data gathered from this study was presented as descriptive statistics including, mean, median, and percentages. Descriptive statistics is often used to describe the data in a more convenient and informative manner for ease of understanding by readers. Because the facility reports its quality data in the form of compliance based on percentages, the researcher wanted to ensure that this project's results were presented in such a way that the staff had familiarity and could relate to the results based on their current quality monitors. Descriptive statistics can also allow the author to see the relationship of a single variable or multiple variables at one time (Polit, & Beck, 2002). This method of analysis allows for description, to compare and to characterize a relationship.

In this 128 bed facility there was a total of 120 potential direct care staff who could be involved in the NHC process on 2 of the six acute units at this psychiatric facility. The two adult units were chosen for this project because of the complexity of both the psychiatric and medical diagnosis of these patients. A total of 58 direct care staff completed and submitted their PBHS surveys which equated to 52% participation. The 58 staff members who completed the surveys included 25 Nurses and 28 Mental Health Technicians. The archival data collected from the PBHS Handoff Communication Survey revealed a wide range of opinions about the current process of NHC being used in the facility. Data for Handoff Communication Pre-Intervention Survey is shown in Table 3. The information gathered in the pre-survey identified three major areas of concern for handoff in this facility which included; information provided is often subjective, handoff is often interrupted and information provided was not often relevant to the patients care. This survey yielded positive things about the handoff process; it is believed that the low return rate is indicative of the lack of true understanding about how critical the process of handoff is to patient care and safety. The survey data and the qualitative information gathered from observations of handoffs and information written in on several survey forms do not correlate at this point. The final question of the survey form asked if staff felt that a change needed to be made to the handoff process and over 82% of the staff surveyed answered yes and many staff made suggestions on the form about what they would like to see to improve the process. Several comments also indicated that the survey form was completed based on their last

handoff opportunity and that the process had a lot to do with who the person was given the handoff and that the information varied daily.

Section 4: Findings, Discussion, and Implications

Summary of Findings

A total of 30 nurses responded to the post implementation survey. Based on the core and prn assignments for the two adult units within the facility, this equated to a participation rate of 90% of the nurses that could potentially be assigned to one of the adult units within this facility. Because the surveys were anonymous there was no way to know the reason why 10% of the potential respondents chose not to participate.

The post surveys were analyzed to determine the effectiveness of implementing a standardized handoff communication tool in a psychiatric setting. Because the facility in its pre-survey decided to focus on the following three particular areas: decreasing interruptions to the handoff communication process, improving the confidence in the information received during handoff and eliminating subjective labeling of patients during the handoff process, the focus of this project was on the development of a process and a tool that would potentially improve these three elements.

Decreasing interruptions to the handoff communication process is critical in the ability of nurses to receive information needed to provide care to their patients. Interruptions can hinder the ability to ask questions or clarify information communicated. Interruptions also lengthen the handoff process and can lead to valuable information being omitted for time saving reasons. Implementing this standardized process and tool in

this facility had minimal impact on interruptions. The post survey indicated an 18% decrease in interruptions from a pre-survey of 33% of the staff feeling like there were too many interruptions to a post survey of 15% feeling like there were continued interruptions.

The second goal of this project was to implement a standardized process and tool that would increase the nurse's confidence in the information communicated during handoff communication. During the pre-implementation survey, the staff indicated that over 47% of the staff felt that the information communicated during the handoff process was not relevant to the patient's care. In the post implementation survey, the staff indicated that only 10% of the staff felt that the information communicated was not relevant to patients care. This equated to a 37% increase in the confidence level of the information communicated during handoff communication within the facility.

The third element of improvement needed was to create a process and tool that would eliminate or decrease the use of subjective labeling of patients during the handoff communication process. During the pre-implementation survey 45% of the staff surveyed felt that the giver of handoff often used subjective labeling to describe the patients. During the post implementation survey, only 4% of the staff surveyed felt that the information communicated used subjective labeling to describe the patient. This equated to a 41% decrease in the use of subjective labeling of patients during the handoff communication process. All post survey data is shown in Table 4.

Handoff communication is intended to enhance the continuity and quality of nursing care given by providing results of nursing assessments, summarizing medical and

psychiatric information, and drawing attention to specific nursing interventions and goals anticipated during the upcoming shifts (Priest & Holmberg, 2000). In order for handoff communication to be effective, there has to be an understanding of its importance by the nursing staff and the leaders of the facility. Nursing staff cannot view the process as just another time consuming activity but one that can potentially prevent errors in care that can cause harm to patients and potential liabilities for them and their facilities in which they practice. As leaders of a facility, it is important to provide the resources needed to complete the task and promote a culture that supports and respects the process.

Implications

In this psychiatric facility the results did not yield the types of changes hoped for, however some improvements were made and the education about the process and its importance yielded value to the facility. As the facility continues to promote the use of the standardized tool, there will be more changes to the form itself and the leaders have committed to more training for the staff on all units within the facility. The leaders of the facility have also committed to the culture of recognizing the times for handoff and trying to keep interruptions to emergencies only.

Because psychiatric nursing is under represented in the literature on this subject and with small incremental changes in this facility , this project further proves the need for education , standardization and a continued focus on improving and mastering the important task of handoff communication in this area of practice, where at present there is no clear delineation of what this process should look like and what information is needed to ensure the continuity of care and safety of the psychiatric patient.

Strengths and Limitations

The strengths of the project for this facility were the open discussion about a topic that is considered one of the missed opportunities in healthcare today. The dialogue and project bought about changes in education and a heightened awareness of the need to improve communication throughout the facility. The project gave nurses the opportunity to participate in improving their practice environment and improving the care they deliver to these patients every day.

The project also had limitations that included the ability to train all of the prn staff who had the potential to work on these adult units of focus. Several training opportunities were offered , however there were still a large number of prn staff unable to attend and had to receive training after the project was initiated which often delayed the beginning of the shift reports. Another limitation of the study was having a post implementation process that allowed the staff to choose participation in the post implementation data gathering process which in the opinion of the researcher led to limited participation ;whereas in the pre-survey conducted by the facility , all staff were approached and encourage to participate. In future projects archival data would not be used in the beginning of the project to ensure the same participants for both pre and post studies in order to have a better comparison of the changes of opinions by the staff.

Self-Analysis

The AACN (2006) describes scholarship and research as the hallmarks of doctoral education. One of the major paradigms of scholarship is that of applying knowledge to solve a problem via the scholarship of application (which is the scholarship of practice in

nursing). As a potential DNP graduate, I believe that I now have the knowledge needed to solve practice problems in nursing through research which can then be translate in to practice that will enhance the delivery of care. As a student, I feel confident in the ability to go forward into my practice environment and beyond to assist others in solving practice problems and developing new and improved programs for the psychiatric community.

As a practitioner, I believe that this experience has placed an indelible mark on my philosophy and practice of nursing from now on. This program has given me a desire to be active in the profession and to be more of a mentor to novice nurses. It is my intention to use the skills learned to ensure that whoever I come across in my practice will know and see through my actions the intention to always provide the best care and influence others to do so as well.

In psychiatric settings , nurses have a constant worry about patient and staff safety due to the potentially unpredictable behaviors of the psychiatric patient in crisis. It is important that nurse pass on information that is current, patient focused and goal oriented to ensure continuity of care. The use of inappropriate psychiatric terminology or subjective labeling of a patient can impede the ability of the patient to receive unbiased care that can diminish the therapeutic benefit of hospitalization. An interruption to the process further impedes the ability to receive and retain information valuable information. Developing a process to communicate critical information during the handoff is an essential nursing skill with serious implication for safe , consistent and effective patient care (Priest & Holmberg 2009).

Section 5: Scholarly Product

The psychiatric nursing community of nursing is under represented in the literature addressing this issue of handoff communication. As a nursing leader in the psychiatric arena, I feel that because this area of practice is so unique there is a need to develop a tool and process that will fit the work done in this community. Priest and Holmberg (2009) identified that a handoff in the psychiatric nursing community can often be convoluted with the desire to focus on the events of the past shift instead of taking full advantage of the unique opportunity to synthesize data from various discipline (e.g., social work ,medicine , and recreational therapy) and develop appropriate interventions for patients. The handoff in this setting provides the opportunity for nurses to contribute to the overall plan of care for patient on these units. This planning contributes to the improvement of consistency and continuity of approach to patient by all shifts (Priest & Holmberg, 2009). Utilizing the skill learned, my plan is to continue to research and improve on this project until I develop a process and tool that standardizes handoffs communication in the psychiatric nursing setting across the country. In 2015, I plan to apply to the American Psychiatric Nurses Association (APNA) to be a presenter to discuss the topic and the need for research on this process of Handoff Communication in a Psychiatric setting. At the point of application I plan to have networked with other leaders in the field and developed relationships that will further the research and hopefully develop a best practice for the specialty of psychiatric nursing.

After completion of this DNP program, I plan to narrow my project down

to write an article for the Journal of Psychosocial Nursing. The Journal publishes feature articles that describe new ideas, clinical strategies, research studies, ethical dilemmas, economic changes, and management directions.

Table 1

Demographic data of Nurses sample

Variable		Value
Nursing experience (years)	Mean	6.2
	Median	5.0
	Range	3mo-32
Psychiatric nursing experience (years)	Mean	10.6
	Median	4.0
	Range	3mo-28
Duration of employment (years)	Mean	6.1
	Median	2.0
	Range	3mo-25

Variable		N	%
Gender	Female	23	92
	Male	2	8
Employment status	Registered Nurse	23	92
	Licensed Practical Nurse	2	8
Employment position	Part-time	5	20
	Full-time	18	72
	PRN	2	8

Table 2

Demographic data of MHT sample

Variable		Value	
Mental Health experience (years)	Mean	7.1	
	Median	<1	
	Range	<1-30	
Duration of employment (years)	Mean	2.6	
	Median	<1	
	Range	<1-14	
Variable		**N**	**%**
Gender	Female	13	46
	Male	15	53
Employment position	Part-time	5	18
	Full-time	16	57
	PRN	7	25

Table 3

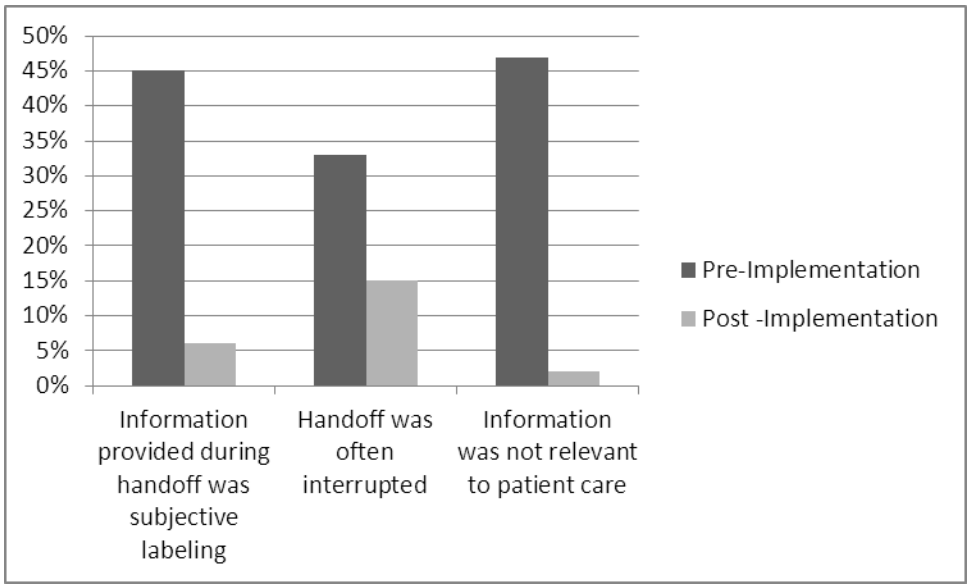
Response to perceptions of handoff process and information

Survey questions	Strongly Agree		Agree		Neutral		Strongly Disagree		Disagree			
	N	%	N	%	N	%	N	%	N	%	N	%
I am able to clarify information that was provided to me.	14	26	34	64	1	1	2	0.03	1	1		
I was able to keep my mind focused on the information provided to me.	17	32	30	56			2	0.03	4	7		
The information provided was easy to follow.	15	28	32	60	2	0.03	2	0.03	1	1		
The information received was up to date.	10	18	30	56	4	0.07	3	0.05	5	9		
The information was relevant to the patient's diagnosis and reason for admission.	28	52	32	60	3	0.05	2	0.03	2	3		
The information provided will allow me to provide care to my patient.	15	28	35	66	1	0.01	1	0.01				
I had the opportunity to answer questions when needed.	12	22	39	73	1	0.01	1	0.01				
The duration of the hand over was appropriate.	10	18	30	56	4	0.07	3	0.05	3	3		
I could obtain handoff communication from the Medical record.	10	18	35	66	8	15	3	0.05	7	13		
There are often discrepancies in what I receive in handoff and the information in the patients' medical record.	4	7	14	26	8	15	8	15	18	33		
The information I received was subjective.	6	11	24	45	11	20	2	0.03	10	18		
Handover is often interrupted by others.	6	11	18	33	3	0.05	6	11	18	33		
All staff caring for the patient is provided critical handoff communication.	5	9	29	55	6	11	5	9	9	16		
I was giving information during handover that was not relevant to patient care.	5	9	14	47	7	13	5	9	9	16		
The information provided was both psychiatric and medical in nature.	9	16	31	58	6	11	4	0.07	5	5		
I was provided adequate information about all patients on the unit.	6	11	26	49	10	18	2	0.03	7	13		
I had to contact the nurse caring for my patients (or nurse in charge) of the previous shift for information about my patients.	3	5	16	30	5	9	6	11	22	41		
Overall I feel that information given to me during	6	11	31	58	5	9	6	11	4	7		

Handoff provides me with information needed to care for patients.											
I was provided information about my patients precaution levels.	7	13	33	62	4	0.07	2	0.03		5	9
The information provided to me could easily be used in an emergency to summarize a patient's condition and progress in treatment.	6	11	32	60	5	0.09	2	0.03		6	11
At the end of handoff, I could adequately pass on information to other disciplines that would keep them safe on the unit.	5	9	32	60	6	11	3	0.05		2	3

Table 4

Comparison of perceptions pre and post implementation



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Appendix A: Handoff Communication Survey

Post Handoff Communication Survey

Unit Assigned_____

Gender_____ Employment Status_____

Duration of Employment_____ Position_____

Years Nursing/Mental Health Exp. ____Years Psychiatric Nursing or MHT Exp._____

Handoff Communication Preference:

Verbal_____ Written_____ Taped_____

Preferred amount of time for handoff communication:

15 min_____ 30 min_____ 45 minute_____

Base your answers on your experience with the new handoff communication tool. If it varies by who you gives you report, complete more than one survey. The goal is to gather information about the process experience and variations.

Questions:	Strongly Agree	Agree	Neutral	Strongly Disagree	Disagree
I am able to clarify information that was provided to me.					
I was able to keep my mind focused on the information provided to me.					
The information provided was easy to follow					
The information received was up to date					
The information was relevant to the patient's diagnosis and					

reason for admission.					
The information provided will allow me to provide care to my patient					
I had the opportunity to answer questions when needed					
The duration of the hand over was appropriate					
I could obtain the handover information from the patient's medical record.					
There are often discrepancies in what I receive in handoff and the information in the patients' medical record.					
The information I received was subjective					
Handover is often interrupted by others.					
All staff caring for the patient is provided critical handoff communication					
I was giving information during handover that was not relevant to patient care.					
The information provided was both psychiatric and medical in nature.					
I was provided adequate information about all patients on the unit.					
I had to contact the nurse caring for my patients (or nurse in charge) of the previous shift for information					

about my patients.					
Overall I feel that information given to me during handoffs provides me with information needed to care for patients.					
I was provided information about my patients precaution levels					
The information provided to me could easily be used in an emergency to summarize a patient's condition and progress in treatment.					
At the end of handoff, I could adequately pass on information to other disciplines that would keep them safe on the unit.					

Would you like to change the style of hand off at this facility? Yes_____ No_____

Comments:

Thank you for taking the time to have your voice heard. Please place completed surveys in the Nursing Administration Mailbox in the Mail Room or slide under the door of Supervisors Office.

Curriculum Vitae

ALICIA R.PLUNKETT

9622 Cedar Mist Cove East ◆ Cordova, Tennessee 38016

(901) 372-7840 Residence ◆ (901) 826-4306 Mobile ◆ alicia2uall@yahoo.com Email

EDUCATION & CERTIFICATIONS

WALDEN UNIVERSITY

DOCTORATE OF NURSING PRACTICE CURRENTLY ENROLLED

WALDEN UNIVERSITY MEMPHIS, TN

MASTERS OF SCIENCE IN NURSING , Fall 2007

UNIVERSITY OF ST. FRANCIS , MT. JOLIET, ILL

MASTERS OF SCIENCE IN HEALTHCARE ADMINSTRATION , 5/2005

UNIVERSITY OF MEMPHIS , MEMPHIS, TN

BACHELORS OF SCIENCE IN NURSING , 1995

P R O F E S S I O N A L / T E C H N I C A L P R O F I L E

University of Tennessee

MEMPIS, TN

Adjunct Professor 10/2011-Present

- Responsible for clinical psychiatric education of MSN nursing students

Parkwood Behavioral Health

Olive Branch, MS

Nurse Executive 4/2007-Prsent

Responsible for 24 hour a day, seven day a week treatment services provided for patients at Parkwood BHS.

Participates with other leaders from administration, medical staff and governing body in developing goals, strategies and mission.

Develops plans, priorities, assessment tools and improvement activities. Analyzes internal and external data.

Represents nursing in management committees, forums and corporate events.

Supervises and evaluates the performance of ADONs, RN House Supervisors, Charge Nurses, RNs, LPNs, MHTs and Dietitians as needed.

Directly observe nursing care on units, reviews records and reports and communicates with staff and patients to assure the effective delivery of nursing care. Takes action promptly when necessary to maintain quality of nursing care

Develops and implements a conceptual framework and model for the delivery of nursing care which reflects the hospital mission and goals.

Develops goals for the delivery of nursing care that are consistent with the mission of the organization.

Oversees infection control practices.

Coordinates clinical experiences of nursing students with schools of nursing.

Assists the HR Director in interviewing, selecting, orienting, training and evaluating nursing staff.

Collaborates with leaders in developing and revising competency assessment program to assess, maintain and improve performance of nursing staff.

Collaborates with leaders in developing and revising plans for staff development, education and training. Uses a variety of sources for education and training.

Prepares nursing budget in collaboration with administration

THE REGIONAL MEDICAL CENTER

MEMPHIS, TN

COORDINATOR, PERFORMANCE IMPROVEMENT 8/2005 –4/2007

Coordinates development of healthcare services for indigent patients within the community and clinic setting

Ensures that programs provide care needed to decrease under and over utilization of services within the community

Coordinates health fairs within the community

Performs quality measures on community health clinics

Coordinates quality and performance improvement activities to assess and review care/services provided and compliance with hospital and regulatory standards and requirements

Provides ongoing monitoring and evaluation of the level of patient care and hospital services

Coordinates performance activities and provides reporting of quality/performance review activities and issues in accordance with established guidelines

Assists in establishing review criteria and standards for measuring and monitoring level of care and services and ensuring compliance with hospital, JCAHO and regulatory agencies' requirements

Aggregates data to assist with the identification of potential problems and hospital patterns, trends, establish priorities and recommend improvement activities

Confers and works collaboratively with medical/nursing/hospital staff to obtain information and resolve problems regarding quality and/or efficiency of patient care and hospital services

Conducts staff in-services, training and orientation on PI process and accreditation standards

Prepares and maintains required reports, records and files

Utilizes computer and information systems to enter format and retrieve data, generate statistics,

computations, tables, charts and graphs.

MEMPHIS MENTAL HEALTH INSTITUE, MEMPHIS, TN

ASSISTANT DIRECTOR OF NURSING, 8/2002-8/2005

Supervised Nurse Managers

Supervised staffing for entire facility

Identified Quality Improvement Projects & Presented QI Project Progress Reports to Executive Council

Implemented Quality Improvement Projects using the Six Sigma Methodology

Advised Nursing Department on JCAHO, CMS & State Standards

Recruited and Retained Nursing Employees

Supervised Infection Control & Employee Health

Completed OJI Reports and OSHA Logs

Monitored time & attendance systems for facility

Reviewed Policies & Procedures & Recommended development of new policies

Educated new nurses & coordinated training & development programs for Psychiatric Technicians

Ordered and monitored utilization of new equipment

LEBONHEUR CHILDREN'S MEDICAL CENTER ,

MEMPHIS, TN

ASSISTANT DIRECTOR OF NURSING, 2/1999-9/2001

Planned & Implemented Performance Improvement Projects

Supervised 25 member staffing unit

Maintained employee files

Educated staff on mental illnesses related to children and adolescents and behavior modification

Administered department budget

Developed policy and procedures

Maintained marketing contacts

Responsible for development of orientation program and annual training for all staff

ST. JOSEPH HOSPITAL,

MEMPHIS, TN

DIRECTOR, CHILD & ADOLESCENT BEHAVIORAL HEALTH 4/1994-12/1998

Monitored Quality Assurance for Adult and Child Behavioral Health Units

Staffed 72 bed child/adolescent unit

Supervised 35 employees including Teachers, RN's, Psychiatric technicians, Social Workers, LPNs and Secretaries

Marketed unit services & Prepared budget for unit

Lead patient education groups

Educated staff on mental illnesses related to children and adolescents and behavior modification

Responsible for development of orientation program and annual training for all staff

Developed policy and procedures

Monitored infection control

MIDSOUTH HOSPITAL

MEMPHIS, TN

ASSISTANT DIRECTOR OF NURSING, 2/1994-4/1994

NURSE MANAGER, 1/1992-2/1994

Managed 4 psychiatric units

Supervised 50-60 Nursing employees

Staffed all units

Monitored Infection Control

Wrote Nursing Policy and Procedures

Produced Nursing Quarterly Reports

Provided support for all staff

Monitored Quality Assurance

Educated staff on growth & development of child/adolescents

Responsible for development of orientation program and annual training for all staff

Staffed child adolescent unit

Supervised 25-30 employees

Lead Patient Teaching Groups

Maintained employee's files

Supervised Weekend & Holiday shifts

UTMG MEMPHIS, TN

RN DIALYSIS SPECIALIST 8/1991-1/1992

Supervised & Staffed LPNs and Dialysis Technicians

Lead Patient Education Groups

Rotated to Regional Medical Center, for dialysis of acutely ill patient in ICU

MEMPHIS MENTAL HEALTH INSTITUE, MEMPHIS, TN

REGISTERED NURSE 8/1990-8/1991

Supervised weekend nursing and teaching staff

Directed care of mentally ill and behaviorally difficult children and adolescents

Rotated to Adult Inpatient Psychiatric Units

Lead Patient/Family Education Groups

THE REGIONAL MEDICAL CENTER

MEMPHIS, TN,

CHARGE NURSE 8/1989-8/1990

Supervised 5 employees

Staffed 23 bed unit

Educated Patients

Educated new mothers on growth and development

ST. JOSEPH HOSPITAL MEMPHIS, TN

STAFF NURSE 6/1988-4/1989

Supervised Certified Nursing Assistants and Licensed Practical Nurses

Provided care of patients on Skilled Nursing Unit

Educated Patients

P R O F E S S I O N A L R E F E R E N C E S

Joni Elrod, LCSW

1612 W Holmes Rd

Memphis, Tennessee 38109

(901) 789-3412

(901) 572-5017

Tina Edgett, RN, MSN

160 American River Drive

Lake Cormorant, Mississippi 38641

(901)489-3437

Joyce Tyler, LPC

30 North Ashlawn

Memphis, Tennessee 38112

(901) 452-0349