# Standardizing Nurse-to-Nurse Handoff Report in the Neonatal Intensive Care Unit

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## Clinical Issue/Practice Problem

- 37 patient adverse events and near misses related to nursing shift handoffs occurred in the NICU at a large, urban, university-based medical center over 12 months (in 2018).
- Root cause: Poor and non-standardized nurse-to-nurse shift handoff communication.
- A need for a quality improvement project.

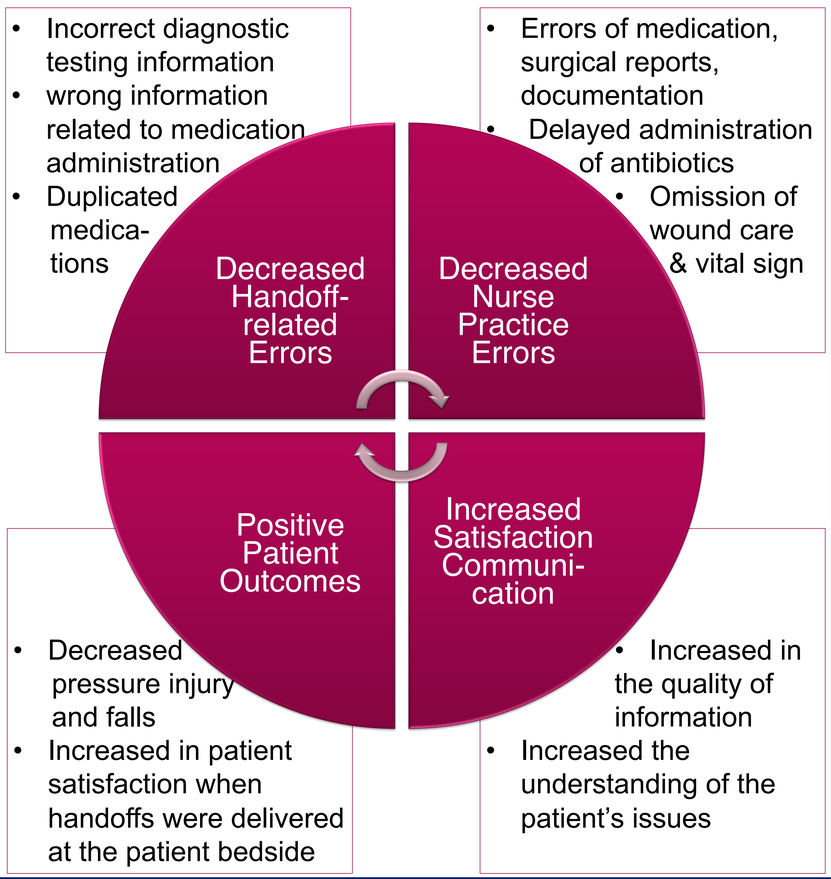
## Objectives

Standardize nursing shift handoff in order to:

- Decrease preventable and nursing handoff related patient adverse events and near misses by 10%
- Increase nurse-to-nurse communication satisfactions to 95%

## Summary of the Supporting Literature

- 5 studies showed the reduction in handoff errors or handoff-related errors.
- 7 studies showed the improvement in nurse practice errors
- 3 studies showed the improvement of interprofessional communication
- 4 studies showed the positive patient outcomes.

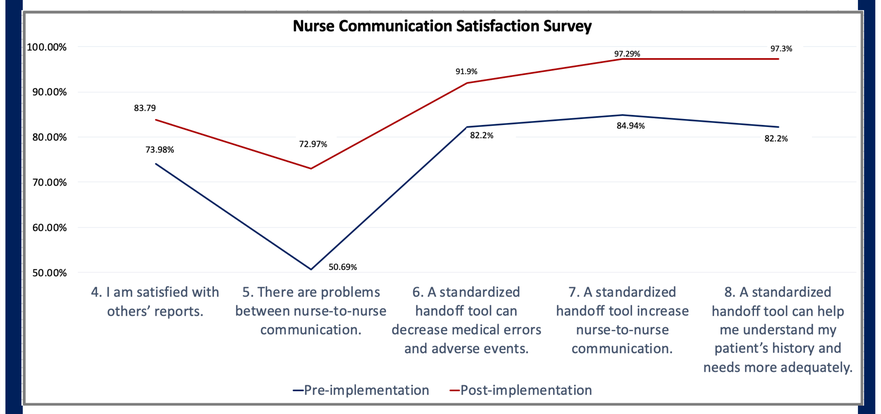



## Project Implementation

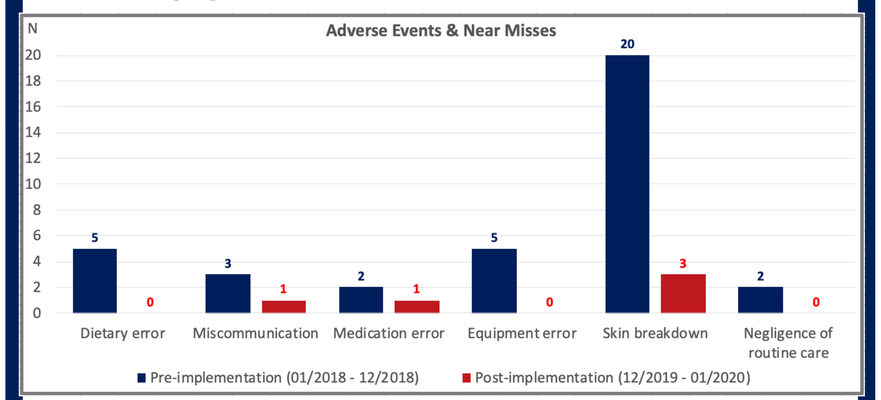
- Participants: 86 NICU registered nurses providing direct patient
- Setting: 48-bed level III, urban, university NICU
- Interventions:
  - Customized a tool specific to NICU: ISBARS
  - ISBARS: Situation, Background, Assessment, Recommendation, and Safety
  - Delivered ISBARS tool to nurses through one-on-on learning training by 6 super users and PD
- Measures:
  - Number of adverse events & near misses were retrospectively collected through the Vizient®.
  - Nurse communication satisfaction was evaluated through the *Registered Nurse Experience Survey.*
  - 50 handoffs were audited for report accuracy, the EHR utilization, and physical examination of the patient.

## Outcomes

- Nurse Communication Satisfaction
  - Satisfied with other's report: 74% → 84%
  - Agreed with the standardized handoff tool increase nurse-to-nurse communication: 85% → 97%

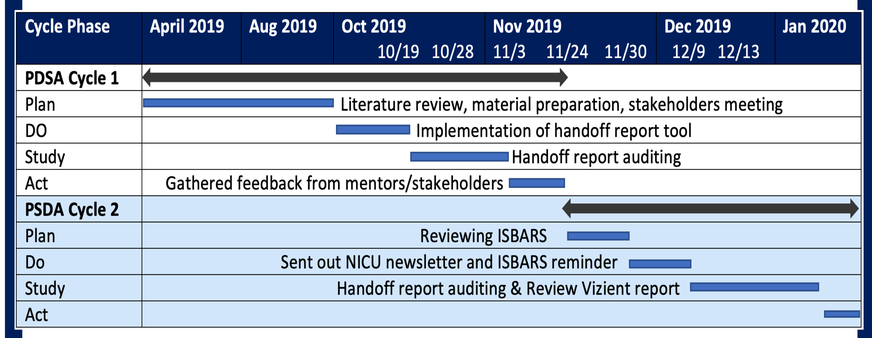



- Adverse Events & Near Misses:
  - Most common adverse event: Skin breakdown
  - No dietary error, equipment error, and negligence of routine care




## Clinical Implications for Practice and Next Steps

- Standardized handoff tool, ISBARS, provided a structure for nursing shift handoff communication.
- It's improved nursing communication and nursing satisfaction of others' reports.
- Continue the use of a standardized handoff process to enhance its efficacy and potentially improve adverse events and patient outcomes.
- Future steps:
  - different root causes
  - across interprofessional personnel

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