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CNL as Outcomes Manager: Improving Communication During the ER to ICU Handoff

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Authors Note

The ER to ICU handoff guide was developed by Amy Ho, July 2018.

Abstract

Emergency room (ER) to Intensive care unit (ICU) handoff reports are often ineffective because the lack of an standardized guideline. The aim of the Clinical Nurse Leader (CNL) improvement project was to improve the nurse satisfaction survey scores in the ER and ICU microsystems within a mid-sized community hospital in northern California. Participates included registered nurses, and ER and ICU managers. The failure mode and effect analysis (FMEA), Strength, weaknesses, opportunities, and threats (SWOT) analysis, and the Plan-Do-Study-Act (PDSA) cycle were used for this project. Literature reviews were conducted to identify effective theories, patterns, and tools for handoff reports. Nurse surveys were conducted to evaluate their satisfaction with handoff reports before and after the quality improvement project. A handoff guide was developed that was influenced by nursing feedback for implementation. Although the goal of improving survey results by 30% following two weeks of project implementation was not achieved, nurse satisfaction still greatly improved by 23% from 54% to 77%. Identification and implementation of a standardized handoff report guide improved nurse satisfaction within the microsystems of ER and ICU. Additional work is needed to ensure 100% compliance and reassessment after long term usage.

Keywords: guide, handoff, reports, education, Intensive care unit, Emergency room, communication, nurse, satisfaction, standardized, effective, survey

CNL as Outcomes Manager: Improving Communication During the ER to ICU Handoff

The purpose of this paper is to elaborate on an evidence-based Clinical Nurse Leader (CNL) capstone project focusing on the Emergency room (ER) to Intensive care unit (ICU) handoff reports. The handoff is a mechanism for transferring primary responsibility and authority; it offers an opportunity to ask or answer questions, and to clarify and/or confirm critical information. This is an analytical process that supports the foundation of safe patient care. There have been a number of identified factors in the handoff report that contribute to inefficiency during patient transfers but communication breakdown remains the leading cause of medical errors and gaps in healthcare (Friesen et al., 2008). This practice improvement project focused on the development of a standardized guideline approach that is effective changes in the ER and ICU microsystems in a mid-sized community hospital in northern California.

Problem Description

The handoff report is a critical time as continuity of care through accountability and responsibility is shifted from one nurse to another. The ER and ICU present with many challenges for effective communication among healthcare providers due to their complex and dynamic work environments (Dunn et al, 2007). The handoff is essentially dependent on the knowledge, experience, and interpersonal communication skills of the healthcare provider. Due to the absence of standardization, ER nurses in these microsystems display variation in the ways they deliver information that is deemed important. This variation in nursing communication patterns leads to ineffective handoffs that contribute to medication errors, incomplete or missing information, delayed and inappropriate treatments, increase length of stay, preventable readmissions, and omitted care. Recent data from the Joint Commission shows that infective communication has remained among the top three causes of sentinel events between 2010-2013

(TJC, 2018). The Joint Commission Center for Transforming Healthcare (JCCTH, 2013), estimated that approximately 80% of serious medical errors are a result of miscommunication.

Rationale

Handoffs have become such a prominent issue that the Joint Commission of Accreditation of Healthcare Organization (JCAHO) initiated a national patient safety goal on handoffs that became effective January 2006 (Catalano & Fickenscher, 2008). The goal requires healthcare organizations to meet the expectations of interactive communications with the opportunity for questioning, providing up-to-date information, verifying received information, reviewing relevant data, and minimizing interruptions during handoffs (Friesen et al., 2008). A survey was developed by the CNL and offered to ER and ICU nurses to understand the communication barriers and causes of ineffective handoffs through their daily experiences. The survey was designed to support the research of strengths, weaknesses, and satisfaction within the handoff reports. By understanding the impediments affecting the staff interactions, we were able to develop a basic handoff guideline that adheres to JCAHO's national patient safety goal and addresses nurse satisfaction, implementation of an intervention that focuses primarily on effective communication, and study the determinants of limitations. The project focuses on answering the following the question: Within nurses in the ER and ICU department of St. Rose Hospital, how does the use of a standardized handoff report guideline compared to not using one increase the satisfaction survey results by 30% within two weeks? The goal is to improve from nurse satisfaction scores from 54% to 85% after an educational intervention.

In order to better understand and identify the current problems related to hand offs, a failure mode and effect analysis (FMEA) was performed. With the valuable information from the FMEA, a fishbone diagram also known as a cause and effect diagram (Appendix A) was used to

visually demonstrate all the possible causes of communication barriers, such as poor teaching and its effect. A SWOT analysis (Appendix B) acknowledged possible threats to the project that will require responsiveness in order to achieve a successful project outcome. The threats include inconsistent compliance, lack of training, communication inconsistencies, and poor interdisciplinary relationships. A Plan-Do-Study-Act (PDSA) cycle based on the Institute Healthcare Model for Improvement, was completed to evaluate the effectiveness of the standardized hand off guideline with communication. The addition of a skilled CNL was also included to provide resources, team leadership and to create a climate for learning and improvement.

A Clinical Nurse Leader (CNL) is a newly introduced role to assist healthcare in meeting higher quality standards through evidence-based practice. According to the American Association of Colleges of Nursing, a CNL is a Master's prepared advanced generalize nurse who assumes accountability for the health care out comes of a specific group of clients within a patient care unit or setting (AACN, 2013). The CNL brings improvements to a system in need of change by being responsible for healthcare outcomes by gathering and utilizing research-based information to design, implement, and evaluate patient outcomes (Moore & Leahy, 2012). Being a leader also entails being a role model and mentor for his or her team by listening to addressed problems and ideas from others with an open mind while displaying the expected qualities (Bender, 2014). A CNL within the ER and ICU can help insure that patients, families, and healthcare provider's needs are not only assess but also communicated in an effective and timely matter.

Specific Aim

The goal of the quality improvement (QI) project described is to determine whether communication between ER and ICU nurses during handoff reports can be improved using a standardized easy to follow guideline. The hospital's ER and ICU departments are currently communicating nurse-to-nurse handoffs without any form of structure, policies, or standards. This resulted in poor results from an internal nurse satisfaction survey and a deeper understanding of the communication gap in quality. The aim of the project is to enhance nurse satisfaction by 30% by the goal date of July 31, 2018. The cause and effect analysis method will be used to thoroughly examine the contributing factors. Once the initial startup and first short-term goal are achieved (Appendix C), the project will continue with long-term goals that include monthly, quarterly, and yearly reviews to implement essential changes within the constantly evolving hospital ER and ICU dynamic work environments.

Context

The project takes place in a private hospital located in Hayward, CA. The hospital is a designated cardiac arrest receiving center in the Alameda county that has a total of 195 staffed beds. The Intensive care unit holds 15 beds and the Emergency room can hold up to 22 beds. On average there are about 5 admits from ER to ICU per day. The Emergency Room (ER) department of the hospital is responsible for providing immediate care to patients of all ages arriving at the hospital. The department provides initial treatment for a broad spectrum of injuries and illnesses 24 hours a day, some of which may require immediate attention because the condition can be life-threatening. Once critical patients are treated and stable enough, they are then transferred to the Intensive Care Unit.

The Intensive Care Unit (ICU) is where seriously ill patients that require close observation, monitoring, and higher level of healthcare professionals, receive around the clock care. Patients are connected to machines to continuously monitor their blood pressure, heart rate, respirations, oxygenation, cardiac output, and heart rhythms. The intensive monitoring allows for immediate anticipated emergency interventions for patients who are medically unstable or critically ill. The ICU healthcare team collaborates to provide assessments, diagnoses, plans, interventions, evaluations, and individualized care for each patient to assist in recovering from severe illness (Redaelli et al., n.d). The patient populations are residents aged 17 years or older whom are admitted from an emergency room, operating room, transferred from another hospital, or from another capacity of care. The admission handoff report will significantly guide the plan of care to project services of routine care such as patient education, laboratories, medications, and treatments. During a recent microsystem assessment, staff in both critical care microsystem indicated an openness and readiness to embrace continuous quality and improvement.

Intervention and Methods

The guide was developed based on experience, acknowledged needs, and evidence based practice from literature reviews. The handoff guide includes three sections: Basic patient information, Emergency room events, and assessment. The first section is basic patient information and it covers the patient's name, age, weight, height, allergies, code status, where they are from, if family are present, and any belongings. The second section is ER events and it covers the patient's chief complaint, diagnosis, past medical history, critical labs, medications given, radiology procedures, peripheral intravenous access, central lines, foley, active protocols, and pending medications and/or procedures. The third section is the physical assessment which

covers each organ system in the following order: neurological, respiratory, cardiology, gastrointestinal, genitourinary, skin, and the patient's current vitals before transfer.

The handoff tool and strategies was taught in mandatory meeting with a combination of ICU nurses & ER nurses for one hour. The beginning of the meeting was presented with a 5 minute slide show of data/statistics, definition of communication/handoff, challenges, and introductory to the ER to ICU standardized hand off guideline approach with a time allotted for hands on training. Following the teaching, a hand out summary of what was discussed and the hand off guideline template (Appendix D) was handed out. Finally, each nurse was paired up with another nurse of a different unit/department to practice handoff reports using the tools and strategies that were taught to fill in the template. The hands-on practice allowed staff to personally implement and evaluate the effectiveness, while building interprofessional relationships between different departments/units. There was 15 minutes apportioned in the end for any questions, comments, suggestions, or concerns. Once each nurse had taken the class, they begun to actively use the guideline for two weeks (Appendix C) during their handoffs. The ER nurses were regularly reviewed to warrant compliance to the handoff guide project.

Study of the Intervention

In 1986, the publication of *Social Foundations of Thought and Action: A Social Cognitive Theory* (SCT) by Bandura advanced a view of human behavior through personal experiences and addressed strategies for improvements. This changing theory is relevant to health communication as it supports the SCT with its emphasis on external and internal social reinforcements. It explains how individuals can learn and be influenced by direct experiences, observations, and interactions, that develop and maintains certain behavior patterns. Self-efficacy, behavior capability, expectations, expectancies, self-control, observational learning, and reinforcements

are the key components related to behavior change (Bandura, 1989). The theory provides the foundation for intervention strategies and how to evaluate behavior change through the factors of people, environment, and behavior (Bandura, 1999). The SCT provides a clear explanation of how people can maintain a goal-directed behavior by applying reinforcement and authority to regulate.

In order to implement the SCT in the ER and ICU, a transformational leader must be able to inspire others to follow the vision. The unit can be extremely busy that healthcare providers are habitually hesitate to learn new tasks and tools due to the extra amount of time and work that must be put in. This can be extremely stressful when the workload is already immense and time is limited. Transformational leadership theory is all about approaching change positively through leaders that are charismatic and strategic (Dvir et al., 2002). They see the big picture and will motivate others by being a role model in order to raise their interest in the Social Cognitive change theory. The leader will recognize the strengths and weaknesses of the followers and challenge their great possession of work with tasks that will enhance their performance (Dvir et al, 2002). The positive outcomes will connect the follower's sense of identity and empower them to surpass standard levels of performance by emphasizing intrinsic motivation (Bandura, 1989).

The assessment of student learning is imperative for demonstrating program success and achievement (Schilling & Applegate, 2012). In order to evaluate the effectiveness of the teaching, there will be a hands on assessment to assess the depth of comprehension and compliancy. In addition, a survey (Appendix E & F) was given before and after the 2 weeks implementation of the project to address if the materials, course, and practice met their expectations. It will also assess the strength of confidence they have in implementing the tools and strategies at work. The survey includes closed questions on the satisfaction and sufficiency

of handoff reports. The survey ends with two open questions to elicit feedback. Once the desired goal to increase the satisfaction survey by 30% within nurses of the program is recognized, exploration of the influential various factors can begin. Program evaluation is a valuable tool to improve outcomes and strengthen the quality by building knowledge (Gesme, 2010).

Measures

To identify any improvements, before and after surveys of staff satisfaction with handoff reports were conducted. The survey is a tool that provides the opportunity to frame effective strategies, improvement in communication, monitor performance, enhance strategic decision making, and meet nurses' expectations with handoff reports. The survey consisted of 5 domains scored on a 1-5 scale, 1 being that they strongly disagree to 5 being that they strongly agree. The last two questions were open ended to allow for feedback . (Appendix E & F). The survey was given to 10 ER and 10 ICU nurses that were actively giving or receiving handoff reports and agreed to participate in the project. It was reported that before the project was implemented, nurse satisfaction was only at 54%. After two weeks of initiating the improvement project, nurse satisfaction increased from 54% to 77% (Appendix G). The daily maintenance log (Appendix H) closely monitored how many ER to ICU admissions there were and if the handoff guide was used during report. It was found that for the two weeks of the project implementation, there were a total of 34 admissions. 27 out of the 34 used the handoff guide during report. The reasoning for the 7 reported noncompliant with the project handoff was due to the handoff not being readily available within close distance, limited time for report, and a very busy shift.

The assessment and result of the improvement project is the beginning of a building block that delivers of great benefits. The overall care and organization of the intensive care unit can be greatly impacted by a thorough clinical microsystem assessment. Growth and

development occurs through awareness by gaining a richer knowledge and understanding of how the system functions. By identifying problems and engaging a multidisciplinary team, the doors open for the opportunity of change that leads to future improvements. An established model for improvement will benefit the process of changing concepts, eliminating waste, improving workflow, enhancing patient relationships, positively changing the work environment, and increasing nurse satisfaction and motivation.

In the workplace, motivation can be defined as an "individual's degree of willingness to exert and maintain an effort towards organization goals", (Franco et al., 2002). Motivation is influenced by a complex set of professional, social, and economic factors. Poorly motivated healthcare workers can have a negative impact on the change strategy affecting the entire health system. It was observed that nurses generally feel motivated and satisfied with their handoff reports when they feel that they are effective and performing well. To overcome the barrier, factors that contribute to motivation and job satisfaction such as adequate communication, listening, compensation, working and living conditions, healthy interdisciplinary relationships, and a strong career development was taught and highly practiced.

Analysis/Discussion

A fishbone diagram also known as a cause and effect diagram, was used to identify possible causes for poor handoff reports that lead to unsatisfied nurses. The probable causes were lack of knowledge on the importance of communication, poor training and motivation to learn, lack of experience with handoff reports, inconsistencies and lack of flow/process with patient information, absence of standardized handoff report, and variation in nursing communication patterns. The Plan-Do-Study-Act (PDSA) was a valuable tool by aiding in development of a

plan, testing the handoff guide change, carrying out the project, learning from the consequences, and determining what alterations should be made to experiment.

A SWOT analysis was a useful technique to understand the strengths and weaknesses, while also identifying the open opportunities and possible threats. The strengths were organized and open communication, standardized handoff approach, management/leadership, improve nurse-to-nurse communication, and improve teamwork. The weaknesses included inconsistencies with communication, poor compliance from ER staff, lack of motivation during training, staff time required to educate on new handoff report guide, and project seen as an additional duty for nurses. The opportunities were to increase staff satisfaction and survey scores, improve patient safety, model for policy change in the hospital, and increase awareness. The threats included potential lack of nurse compliance that lead to no changes and inconsistencies with use to guideline due to busy shift.

Ethical Considerations

Effective ER to ICU handoff reports increases valuable communication, provides accurate patient information, supports the foundation of patient care, and decreases medication error and gaps. Handoff reports are significant and it is the nurses responsibility to ensure that pertinent information is reviewed. Despite the significance, handoff reports in the hospital often appears to be inadequate. Therefore, a maintenance log was used to study the quantity of ER to ICU admissions and the usage of the handoff guide during report. In addition, a satisfaction survey was used to study the effects and outcomes of the new handoff guide. The study demonstrated that the pattern of using the handoff guide was inconsistent throughout the two weeks period. The failure in the study facilitated with the identification of nurse noncompliance

such as busy shifts and guideline not readily available for use, to work through barriers in order to effectively use the guideline accordingly.

Results

The ER to ICU handoff nurse satisfaction survey before the project implementation was only at 54% (Appendix G). Nurses feedback on handoff weakness or barriers included that handoffs were often rushed, disorganized, had no flow, and missed valuable information. The suggested feedback on how handoff reports could be improved included a guide to help with organization, reporting patient information, events in ER, and then assessment last, not rushing the report, and know all patient information before giving report. Over the course of the two weeks study, there were a total of 34 ER to ICU admissions. Barriers such as handoff guide not readily available within close distance and limited time caused 7 of the handoff reports to neglect the use the of guide (Appendix H). The amount of the project time, the intervention was actually used as intended. Unfortunately, the initial goal of increasing the satisfaction survey by 30% was not met. The after project implementation survey resulted in 77%, increasing the satisfaction by 23%. The reported feedback included that the guide took valuable time during busy shifts, inconsistencies with the usage, nurses skipping information on the guide they deem not important, and little to no motivation on the outcome benefits.

Summary and Conclusion

The CNL implemented a quality improvement project by applying evidence-based practice in order to design intervention models of care delivery from collection and evaluation of data. Being a change agent for the healthcare facility requires encouraging other to actively listen, clearly communicate standards and build strong trusting relationships with coworkers (Bender, 2014). Effective communication has many requirements that need to be fulfilled. The

healthcare is complex and often demanding, it requires a lot of guidance and patience with communication among colleagues. It was evident that the ER to ICU handoff report were ineffective and hindering the interpersonal relationships along with patient care and safety. The project was aimed to improve nurse satisfaction by developing a handoff guide that would structure, organize, simplify, and ease the reporting process. Although the goal to improve the nurse satisfaction survey by 30% was not achieved, the survey was still increased by 23% from 54% to 77%.

Nurses reported that the handoff guide has significantly and effectively impacted the handoff report. The handoff guide remains to be actively used daily during reports with no intentions to discontinue to usage. With proper strategies and interprofessional relationships, the effectiveness of communication can be reached and supports one's own development mentally, physically, and psychologically (Vertino, 2014). Applying the skills and knowledge will lead to healthier healthcare providers that will impact patients and lead to efficient quality care.

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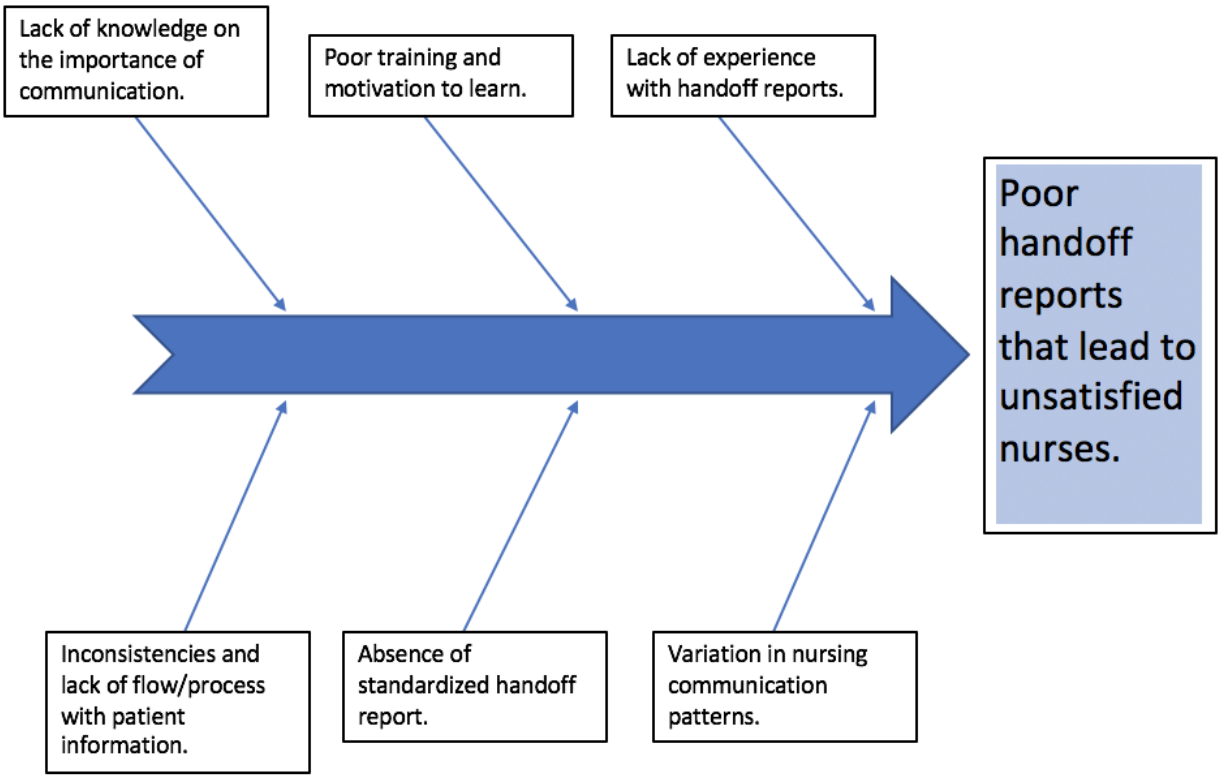
Appendix A

FISHBONE DIAGRAM



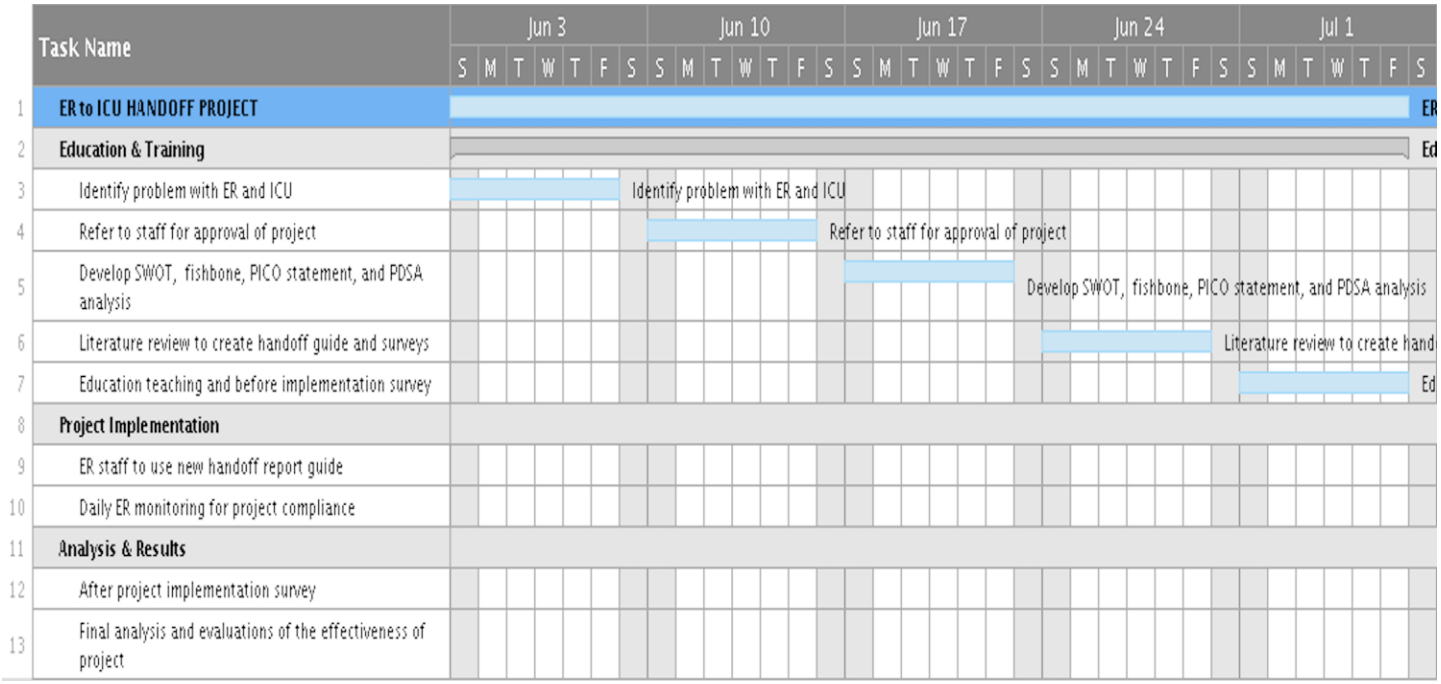
Appendix B

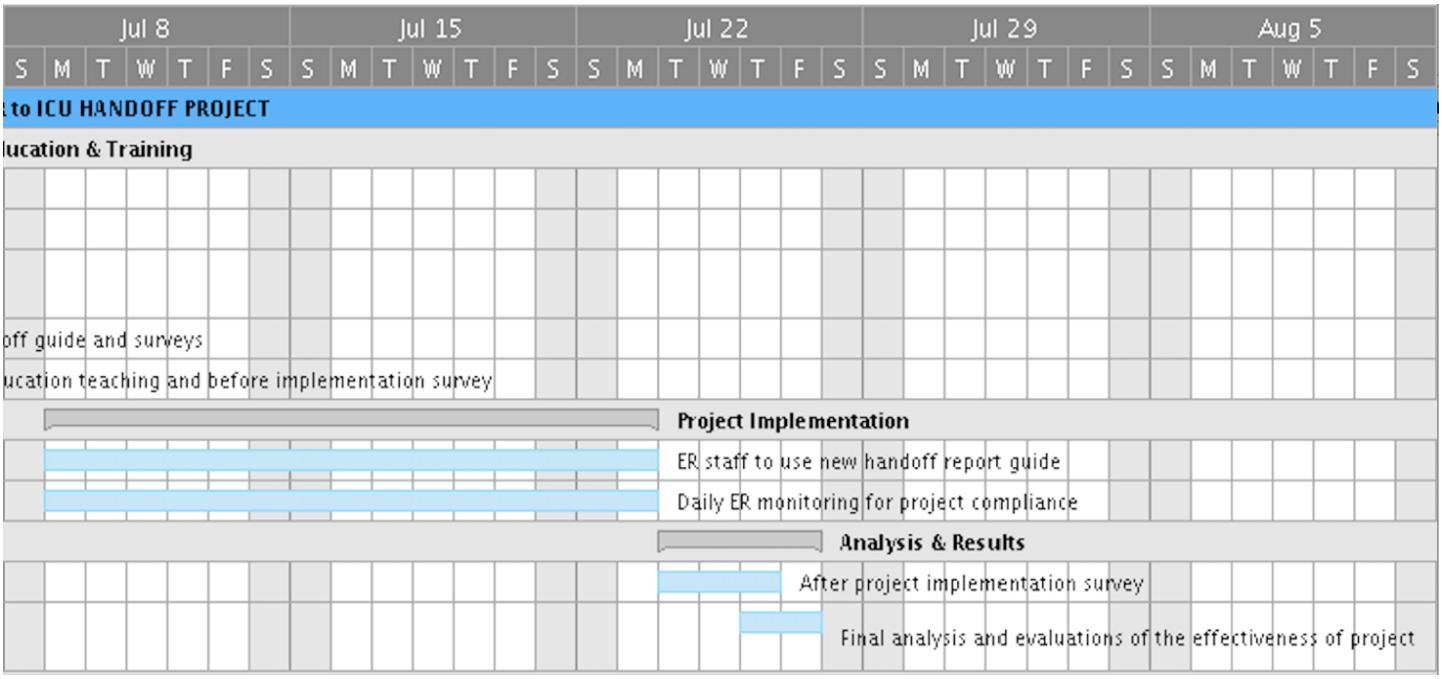
SWOT ANALYSIS

Strengths	**Weaknesses**
• Organized and open communication • Standardized handoff approach • Management/Leadership • Improve nurse-to-nurse communication • Improve teamwork	• Inconsistencies with communication • Poor compliance from ER staff • Lack of motivation during training • Staff time required to educate on new handoff report guide • Seen as an additional duty for nurses
Opportunities	**Threats**
• Increase staff satisfaction survey scores • Improve patient safety • Model for policy change in the hospital • Increase awareness	• Potential lack of nurse compliance, leading to no changes in satisfaction • Inconsistencies with use of guideline due to busy shift

Appendix C

GANTT CHART





Appendix D

ER TO ICU HANDOFF GUIDE

ER Nurse:_____ ICU Nurse:_____ @_____

1. Basic Pt Information

1. Name:
2. Age:
3. Wt / Ht:
4. Allergies:
5. Code Status:
6. From:
7. Family Present / belongings:

2. ER Events

1. Chief complaint:
2. Diagnosis:
3. PMH:
4. Critical Labs:
5. Medications given:
6. Radiology procedures:
7. IV / Central lines:
8. Foley:
9. Active protocols:
10. Pending Meds / Procedures:

3. Assessment

1. Neuro:
2. Resp:
3. Cardio:
4. GI:
5. GU:
6. Skin:
7. Current Vitals:

Created by Amy Ho, July 2018

Appendix E

ER to ICU Handoff Report Satisfaction Survey: Before guideline

1. The handoff reports I give or receive are organized and detailed with valuable information.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

2. The report I receive or give is sufficient for me or the nurse to provide care for the patient.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

3. Nurse-to-Nurse handoff reports allows me to prioritize my workload.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

4. How satisfied are you with giving or receiving handoff reports?

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

5. I feel comfortable approaching a busy co-worker to obtain missing information from the handoff.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

6. In your experience, what are some weaknesses and/or barriers to handoff reports?

7. What are some suggestions that can be done to improve the handoff reports?

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Appendix F

ER to ICU Handoff Report Satisfaction Survey: After guideline

1. The guideline helped save valuable time while receiving or giving report.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

1. The guideline ensured that all critical information were acknowledged and reported.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

2. Nurse-to-Nurse handoff reports were much more effective with the guideline.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

3. I am satisfied with giving or receiving handoff reports using the guideline.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

4. I will be using the guideline while giving report in the future.

Strongly Disagree 1	2	3	4	Strongly Agree 5
○	○	○	○	○

5. In your experience, what are some benefits to the handoff report guideline?

6. Do you have any questions, concerns, or comments in regards to the guideline?

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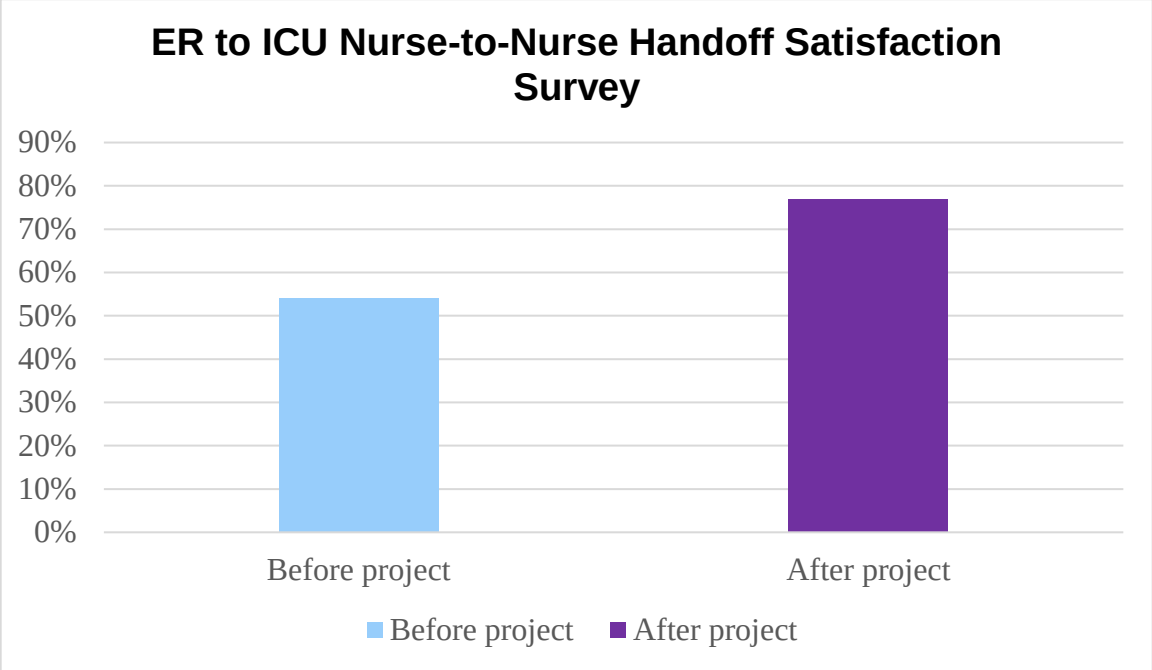
Appendix G

Survey Results



Appendix H

Maintenance Log

Date	Time	Pt's age	Diagnosis	Guide used
1. 7/9/18	0605	35	Acute Respiratory failure	Yes
2. 7/9/18	1035	65	Altered Mental Status	Yes
3. 7/10/18	0123	74	Upper GI bleed	No
4. 7/11/18	0545	66	Diabetic Ketones Acidosis	Yes
5. 7/11/18	1915	72	Altered Mental Status	Yes
6. 7/11/18	2337	55	Severe Sepsis	Yes
7. 7/11/18	2357	26	Preeclampsia vs "wet tap"	No
8. 7/12/18	0215	34	ETOH	No
9. 7/12/18	0453	59	STEMI	Yes
10. 7/14/18	1554	45	Hyperkalemia	Yes
11. 7/14/18	1720	55	Pulmonary Embolism	No
12. 7/15/18	0045	69	STEMI	Yes
13. 7/16/18	0715	81	Respiratory Distress	Yes
14. 7/16/18	0945	72	Sepsis	Yes
15. 7/16/18	1422	45	Uncontrolled A-fib	Yes
16. 7/17/18	0145	67	NSTEMI	Yes
17. 7/19/18	0421	77	Cardiac Arrest	No
18. 7/19/18	2115	72	COPD	No
19. 7/19/18	2311	88	Pleural Effusion	Yes
20. 7/20/18	0010	81	STEMI	Yes
21. 7/20/18	0317	64	Respiratory Distress	Yes
22. 7/21/18	0555	58	STEMI	Yes
23. 7/21/18	0731	72	Altered Mental Status	Yes
24. 7/21/18	0939	48	Sepsis	Yes
25. 7/21/18	1126	53	Hypoglycemia	Yes
26. 7/22/18	2325	94	Respirable Crystalline Sillica	Yes
27. 7/22/18	0423	82	Syncopal Episodes	Yes
28. 7/22/18	0645	76	Seizures	Yes
29. 7/23/18	1017	68	GI bleed	No
30. 7/23/18	1541	79	Respiratory Distress	Yes
31. 7/23/18	1633	86	Bowel Obstruction	Yes
32. 7/23/18	2210	96	Altered Mental Status	Yes