

ABSTRACT

The clinical handoff is an integral part of nursing care. Nursing Intake is responsible for order entry for the patients on service with the home health agency. The orders entered lacked uniformity for the field clinicians accountable for implementing them. Joint Commission has identified a need for standardized handoff with an electronic medical record template to decrease the risk of adverse patient safety events. As patients transition between care settings, there is an increased risk for errors due to inaccurate handoffs. There is no standard template for a handoff when patients come onto homecare services. This MSN project aims to address the lack of standardization of this handoff process between nursing intake and field clinicians in the home health setting.

PICO QUESTION

Registered Nurses working in Nursing Intake, how does the development of a standardized form for recording nursing intake orders compared to the current process improve the accuracy and implementation of orders by the healthcare team working in the home health setting implemented within the 48 hours of the order being received?

LITERATURE REVIEW

After a thorough literature review, three themes were identified:

1. Use of a Standard Template for Patient Hand Offs
 - Nursing leaders should create structured handoffs tailored to their units to reduce the rates of hand-off-related errors. ⁽⁶⁾
2. Template Superiority
 - Literature supports the use of a standardized template. Education and training about standard hand-off support increase understanding of patient identity, situation history, systems review, and recommendations (ISBAR). ⁽⁴⁾
 - Hand Off depends on the nurse's experience and personality. Nurses may include too much information or not enough information. ⁽³⁾
3. Customizable Template
 - Developing and implementing a change in handoff requires a customized approach, time, implementation methods, and support. ⁽¹⁾

Order Template for Nursing Intake

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PROJECT METHODOLOGY

Handoff between caregivers has been identified as the leading causes of patient safety events. ⁽⁵⁾ The Center for Medicare and Medicaid Services has outline quality improvement strategies by changing how care is given by teamwork and better coordination. ⁽²⁾ This project aims to reduce errors between the nursing intake team and field clinicians in the home health and hospice setting by creation of a standardized handoff template within the electronic medical record.

The project will begin with staff education and potential impact of inadequate order entry and handoff between nursing intake and field clinicians. The education will utilize examples of missed orders and improper handoff.

Plan and Development

Education

- Education of staff on the potential impact of a standardized template.

PowerPoint

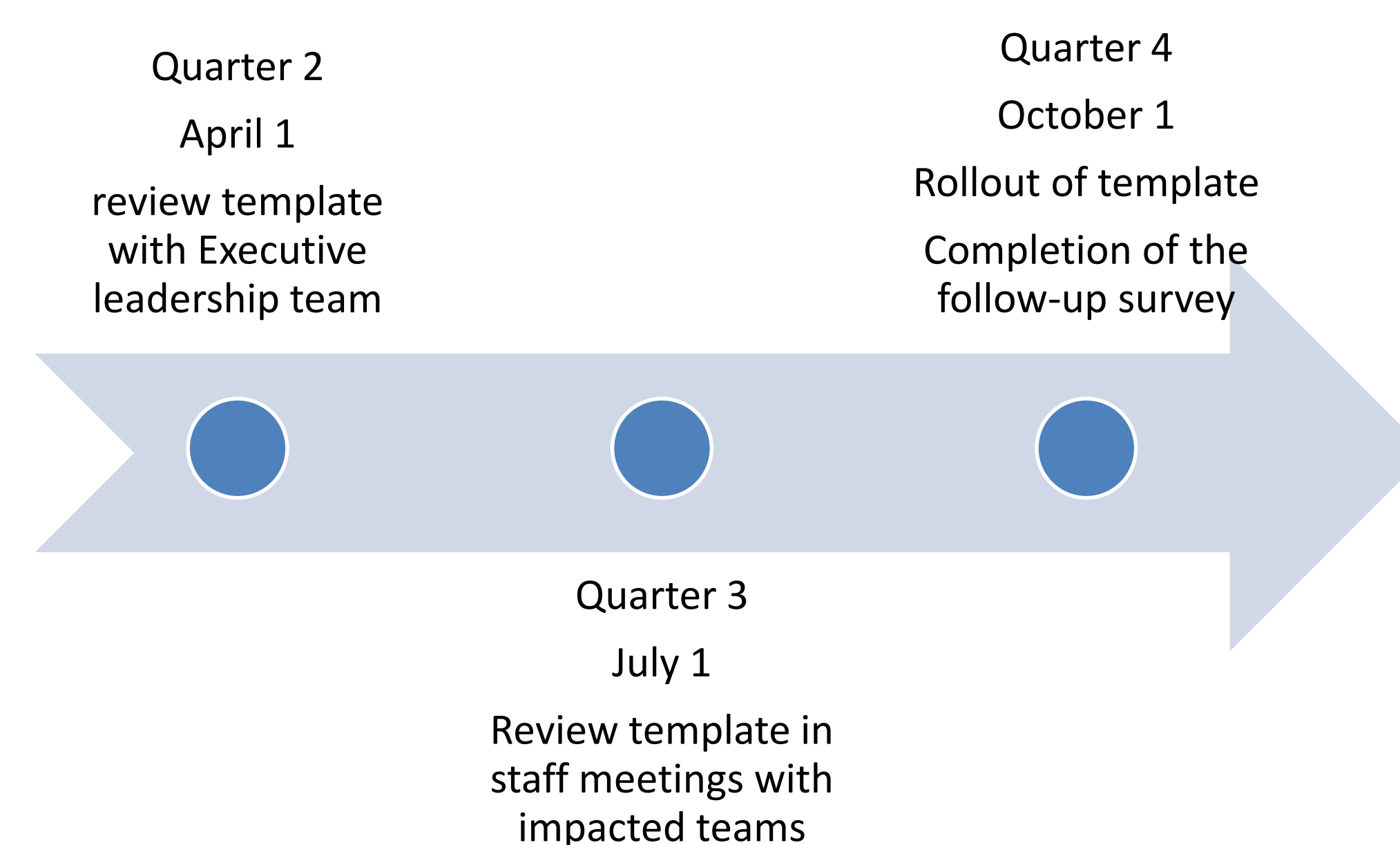
- Safety events from previous 2 years
- Errors related inaccurate order entry
- Rate of errors
- Training and resource guide

Prototype Template

- Include feedback from nursing leaders and front-line caregivers before implementation
- Based on services provided in home health setting

Evaluation

- Success of the project will be measured by reduced safety errors and improved handoffs between nursing intake and field clinicians.
- Subjective data from the home health clinicians about the uniformity of orders and the impact to their workflow.
- Template feedback from Nursing Intake on the impact to their workflow.
- Data from patient safety events prior to implementation and post implementation will determine if this project is successful



INACCURATE ORDERS CAUSE 74% OF ERRORS

- Goal is reduction of order entry errors
- Standard template so all orders are uniform in appearance for field clinicians
- Feedback is desired from nursing intake staff and clinical caregivers
- Implementation will begin on next quarter



THEORETICAL FRAMEWORK

JOHN HOPKINS NURSING EVIDENCE-BASED PRACTICE MODEL

The John Hopkins Nursing Evidence-Based practice model uses a problem-solving approach to decision-making that uses scientific evidence and clinicians' experiences.

The John Hopkins model ensures that current research and best practice are implemented regarding patient care and the care being provided.

CONCLUSIONS

The use of a standardized template is well documented and established as Evidence-Based Practice. Findings support customizable, standardized templates for patient handoff as part of the electronic medical record.

The project incorporates the importance of standardized template use and the need to create a customizable template to maintain the highest patient safety outcomes. Inhibiting factors include compliance with standardized template implementation and resistance to change by staff.



Figure 1

REFERENCES

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3. Hada, A., Jack, L., & Coyer, F. (2019). Using a knowledge translation framework to identify barriers and supports to effective nursing handover: A focus group study. *Heliyon*, 5(6), e01960.
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FIGURES

1. Microsoft PowerPoint (2021) Photograph