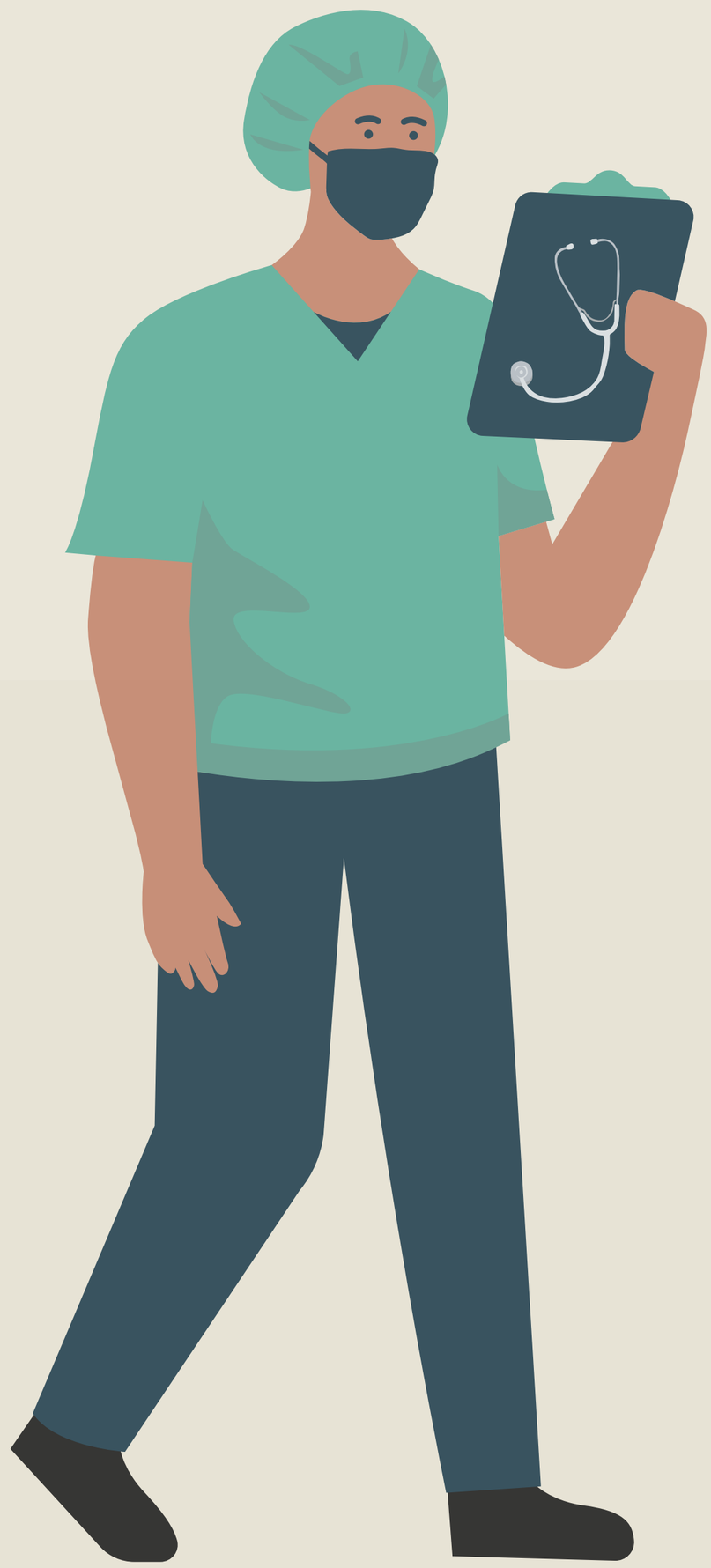
BECOME A

HANDOFF REPORT MASTER



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What does the perfect handoff report include?

Change of shift report can be a challenge, even for the most experienced of nurses. A good change of shift report must be:

1. Clear: Given in an organized fashion.

2. Concise: Discuss relevant information only

3. Quick: Report should be given/received in a timely manner

Patient (and nurse) safety is a priority that can be enhanced with a proper report.

WHAT SHOULD YOU INCLUDE IN REPORT:

Diagnosis or Chief Complain
Code Status, Allergies,
Relevant History
Latest Vitals
Baseline and Current Condition
Important Diagnostic Results
Pending (meds, tets/procedures, etc)
Plan of Care

This is great, but in what order and why?!

Why structure?

Have you ever had an extremely busy day on the unit? There's so many things happening at once, charting at that moment is not feasible.

So, you grab a napkin & jot down the plan of care the doctor just discussed with the patient. Just a few minutes later case manager comes to the nurses' station to update you on your patient's discharge plan, so you jot that down on a sticky note you found nearby. Therapy wants you to call the doctor for a new order, and your patient just fell! Because of his history a CT scan is ordered, but will pending for next shift because, yes, it's change of shift now. If every single time you grab a different piece of paper how are you going to follow up on this or inform the next nurse it is pending without running the risk of missing something?

The Joint Commission encourages structured hand-off using mnemonics such as I-PASS and ISBAR.

Using a structured form of handoff has shown to improve patient safety by reducing adverse evets and medical errors. A good handoff can also promote nurse safety and satisfaction.

WHAT IS I-PASS?

I - Illness Severity

P - Patient Summary

A - Action List

S - Situation Awareness
and Contingency Planning

S - Synthesis by Receiver

I-PASS was created in 2010 as a tool for resident physicians. It helped standardize their shift hand-offs and highlight how it improved patient safety. After several studies, it is now used across many facilities and specialties.

I-PASS

I - Illness Severity

- What is their acuity? Are they stable, a "watcher," or unstable

P - Patient Summary

- Summary statement, Events leading up to admission/visit, Hospital course, Ongoing assessment, Plan

A - Action List

- To do list, Time line and Ownership

S - Situation Awareness and Contingency Planning

- Know what's going on, Plan for what might happen

S - Synthesis by Receiver

- Receiver summarizes, Asks questions, Restates key action/to-do items

CHART OBTAINED FROM I-PASS PDF

EXAMPLE:

I - Illness Severity

This is a stable patient. She's a full code.

P - Patient Summary

Jane Smith is a 24 year old female with no previous medical history or known allergies. She came in with sudden sharp RLQ pain 8/10 and nausea. CT scan confirmed appendicitis. WBCs are elevated at 13. She's had 4mg Zofran and 4mg of Morphine, and is currently receving 1g of Rocephin. Afebrile, vital signs stable.

A - Action List

We're pending surgery consult. Surgeon has been paged and we're just waiting for call back. The Rocephin will need to be turned off in about 15 minutes, when it's done infusing.

S - Situation Awareness and Contingency Planning

She will likely be admitted for surgery. The ER Dr. already informed pt & we're just waiting for surgeon to call back. She's resting comfortably, but if her pain returns there is an order for PRN morphine.

S - Synthesis by Receiver

Ok. So Jane Smith a 24 year old female, full code with confirmed appendicitis. She will likely be admitted for surgery, we're just waiting for surgeon to call back. I will turn off the Rocephin in about 15 minutes when it's done infusing, and if her pain returns I will give her a 2nd dose of Morphine as ordered.

EXAMPLE:

I - Illness Severity

This is a stable patient. She's a full code.

P - Patient Summary

Jane Smith is a 24 year old female with no previous medical history or known allergies. She presented to the ED with sudden sharp RLQ pain 8/10 and nausea. She's admitted with a diagnosis of appendicitis. She is scheduled for a lap vs open appendectomy with Dr. Doe later today.

A - Action List

Her consent has been signed and is in the chart. We're pending to give OR report, but the nurse will call back.

S - Situation Awareness and Contingency Planning

She will likely be discharged home within the next 24 hours.

S - Synthesis by Receiver

Ok. So Jane Smith a 24 year old female, full code with confirmed appendicitis. She will be having a lap vs open appendectomy today and will likely be discharged within the next 24 hours. I will give report to OR when the OR nurse calls back.

I-PASS VS SBAR

While I love the ISBAR/SBAR structure, I find it more efficient when escalating a problem or communicating with physicians. I-PASS seems more structured to give change-of-shift report. Whichever you prefer, make sure you always follow your facility's protocols first.

Depending on the care setting, you may need a more detailed assessment. For example, in the ER you will not necessarily report a detailed head-to-toe assessment for every patient. In the ICU, however, a comprehensive assessment is crucial and can make a difference on the patient's course of stay.

If you're struggling with staying organized during your shift, you may also struggle when it comes time to give report at the end of your shift. You may find yourself writing little notes on random pieces of paper or napkins throughout the day. At the end of the shift, you're left with so many sheets you don't know which note is important or which piece of paper you can toss. This can prevent you from sharing vital information with the oncoming nurse. If you need a better way to stay organized and give a perfect, concise report I invite you to try these report sheet templates. I've used at least one these variations throughout my entire bedside career, and it's certainly helped me stay focused on relevant details and pass on the important details.