The Problem
In June 2014, the MICU/SICU East (Finard ICU) implemented the PCS Daily Management System (DMS). One of the Quality Metrics that the nursing staff chose to measure was change of shift bedside handoffs:

- Although patient handoff always occurs between shifts, the nurses thought we could improve how often our patient handoffs occurred at the bedside in the ICU.
- Per BIDMC Critical Care Practice Manual, (CCG-302) Change of Shift Nursing Report for the ICUs:
  - “…A handoff at the bedside should include a review of the patient’s clinical condition and all technology attached to the patient is assessed….”
- Although change of shift patient report is comprehensive and includes reviewing the electronic documentation and an opportunity for questions, by not consistently performing handoffs at the patient’s bedside we could miss opportunities such as, real-time reconciliation of IV fluids/medications infusing, subtle patient changes noted in nursing assessment, introduction of oncoming RN to patient/family, additional verbal exchange between caregivers for questions/clarification, etc…
- Represents IOM Dimensions of Quality Care of Safety and Patient Centeredness

Aim/Goal
Our goal is for each patient to have a bedside handoff report in our ICU.

The Team
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- Beatrice Fleury, PCT
- Susan Holland, RN, MS
- Elsy Jaison, RN, BSN
- Christine Joyce, RN, BSN
- Susan Kitchen, RN, BSN
- Lisa Mirabella, RN, BSN
- Emily Thompson, RN, BSN
- Patricia Wenger, RN, BSN
- Finard ICU staff

The Interventions
- Data was collected from 10/1/14 to 11/24/14 at our DMS huddles - All nurses reported if patient handoff occurred at the bedside.
- In addition to all RNs reporting if bedside handoff occurred or not, they were asked “why” it did not occur when the goal was not met. These reasons for not achieving the goal were tracked to identify barriers. At baseline, the first week of data collection, showed that handoffs were not performed for over 25 handoffs at patient bedsides.
- If handoff did not occur at the bedside, the reason why was recorded to identify trends/barriers.

The Results/Progress to Date

Lessons Learned
- A trend initially noted was knowledge deficit about our guideline in critical care and education provided during our DMS huddles and staff meetings.
- Through huddle discussions, determined that there may be some patients who may not be able to have handoff at their bedside to provide the best care possible to the patient (i.e., a patient experiencing sleep deprivation/delirium who just fell asleep).

Next Steps/What Should Happen Next
- Monitor for sustained improvement by adding this again to our Daily Management System as a Quality Metric within the next year.
- Share results with other ICUs who will be implementing the DMS within the next year and may consider this as a future Quality Metric if identified as an area for improvement in their unit.

For more information, contact:
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