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Care Coordination and Handoff for the Pediatric Patient in the Radiology Environment

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A B S T R A C T

Handoff refers to the process of transferring the responsibility of patient care from one care provider to another in support of coordination of care. It is a real-time progression of transferring specific information to ensure the continuity of care. This fundamental but imperative process in patient care ensures that this pertinent information is discussed between team members while including the pediatric patient and often the parent or caregiver. Although easy to move through this process quickly, the hand-off process is one of significant importance for the coordination of ongoing care for the pediatric patient. Using information from the literature reviews, perception surveys from team members, and a collaborative review of the existing radiology hand-off process, the work supporting change to handoffs resulted in development of a more robust education and template for improvements to support quality patient care for the pediatric patient. This article will discuss the concepts for care coordination and handoffs for the pediatric patient on the radiology environment. Suggestions for staff nurses, nurse managers, radiology technologists, and physicians will be discussed in support of the pediatric patient when transitioning from levels of care within radiology and to other areas for care.

Introduction

Handoffs are extremely important to all patients and significantly vital in the pediatric population. The communication of information, accountability, and impact between providers can pose serious safety risks when not presented effectively to ensure care coordination at all levels of pediatric care. Accurate and efficient handoffs with an implemented standardized approach between staff, change of shift, and between different patient care units in the course of a transfer of care support strategies by the Joint Commission (2007), The Agency for Healthcare Research and Quality (2013), and the Institute of Medicine (IOM, 2001). In 2001, the IOM recommended focusing on hand-off processes to improve patient safety. The Institute of Medicine (IOM, 2001) reported that “it is in inadequate handoffs that safety often fails first” (p. 45).

Although handoffs can be considered lengthy while decreasing a quicker response to the continuation of care, it is a beneficial and often pivotal point for the coordination of care for not only the pediatric patient but also for the parents and guardians in support of the ongoing care. Pediatric care coordination is a patient- and family centered, assessment-driven, and team-focused event that supports the needs of children while enhancing the abilities of the family and guardian while under the care of the nursing and medical team. Care coordination with the proper handoff should be proactive, planned, and comprehensive to ensure all aspects of care have been considered with a focus on continuous communication. A fundamental goal during handoffs is to provide an accurate and complete report to the next care provider to ensure that relevant care information is discussed, plans of care are reviewed, and patient care outcomes can be achieved. Each transition or handoff to another level of care has the potential to create an adverse impact on patients because the coordination of care can be negatively impacted without the hand-off information. Effective handoff of information is critical as the lack of significant hand-off communication between care providers can be a major contributing factor for sentinel events. Handoffs with information variability has also contributed to errors, care omissions, treatment delays, and inefficiency from duplicated work. It has also contributed to adverse events with minor or major harm, the potential for an increased length of stay, avoidable readmissions, and often

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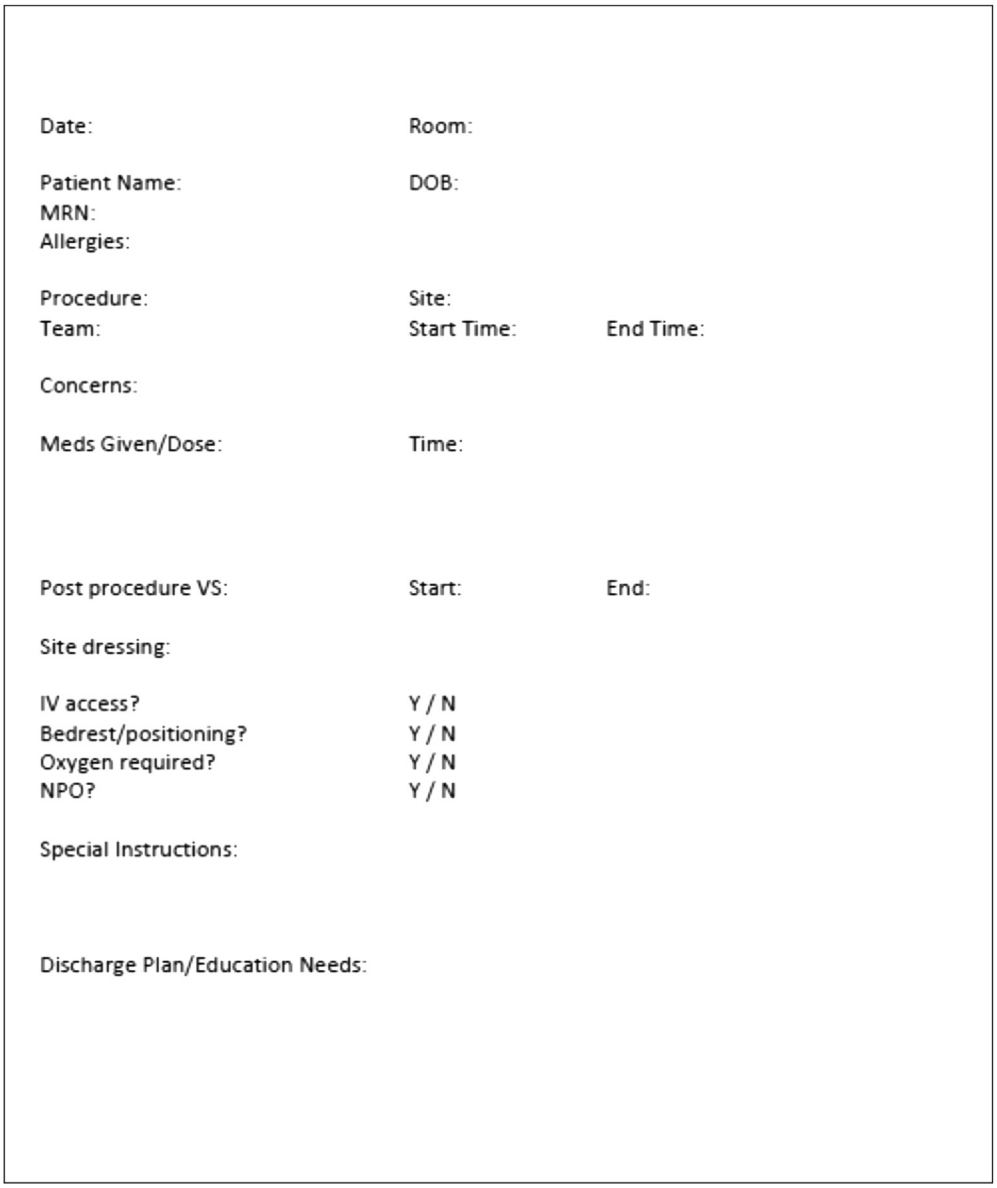
increased costs to the patient (Halm, 2013). The handoff was quickly identified by the team as an opportunity to strengthen patient care and enhance the current workflow.

Identified opportunities

Within the radiology nursing department, the opportunity was recognized as not all aspects of handoffs were consistent not only internally but also to the inpatient units. Many times, certain aspects may have been missed that could have concluded in a change in the care of the patient. Through many reviews of cases and more specifically looking at ways to become more efficient with our patients and team members, this opportunity began to evolve. Handoffs are performed in many areas within radiology including transport and within the modalities. There are competencies and core functions of handoffs: who should provide it, what the desired outcomes are, and how to measure with a focus on care coordination. Care coordination is an important part for the radiology nurse environment and supports not only the pediatric patient and family but also other team members in providing care to the patient during and after visiting the radiology department. As part of the care coordination under the purview of radiology care, the hand-off needs were identified, and the shift in focus evolved to the support all patients including the pediatric population where parents and caregivers are a vital aspect of the care coordination.

Nursing students' project

At this teaching hospital, many students have clinical rotations through radiology. Each student has the ability to observe and shadow a team member, to rotate through many modalities within radiology, and ultimately to focus on a project to support radiology nursing and the course curriculum. As part of the semester's project, two BSN students were invited to observe, survey, and research handoffs specific to the radiology environment. Jeffcott, Evans, Cameron, Chinn, and Ibrahim (2009) proposed that to improve the gaps in knowledge around the concept of handover, it is important to be able to measure the safety and quality of the


Date: Room:

Patient Name: DOB:
MRN:
Allergies:

Procedure: Site:
Team: Start Time: End Time:

Concerns:

Meds Given/Dose: Time:

Post procedure VS: Start: End:

Site dressing:

IV access? Y / N
Bedrest/positioning? Y / N
Oxygen required? Y / N
NPO? Y / N

Special Instructions:

Discharge Plan/Education Needs:

Figure 1. Radiology hand-off sheet. DOB = date of birth; MRN = medical records number; IV = intravenous; NPO = nothing by mouth.