

Standardizing Observation Handoffs: A Tool to Improve Communication and Safety in High-Risk Patient Care



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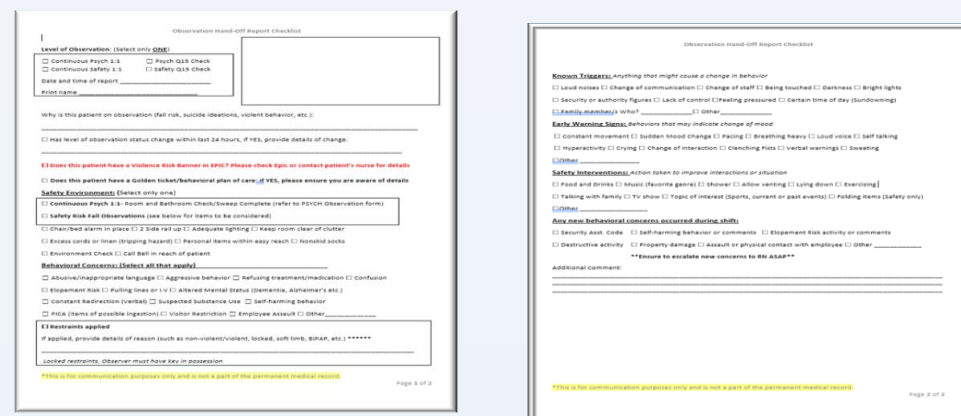
INTRODUCTION

Background:

- Increased reports of safety events during 1:1 observation at Virtua Mount Holly (**18%**)
- Debriefs identified communication failures as a major risk to patient and staff safety.
- Observer handoffs were informal, lacked structure, and often missed critical behavioral and clinical data.
- These gaps contributed to reduced staff confidence and adverse outcomes.
- Recent evidence suggests that structured handoff tools—including behavioral risks and triggers—significantly improve safety communication, resulting in clearer and more effective care for high-risk patients.(Hawley et al., 2023)

Purpose:

- This Quality Improvement (QI) project aimed to enhance clarity, consistency, and effectiveness of handoffs for direct observation through the implementation of a standardized Observation Handoff Tool.



Framework:

The initiative followed the Plan-Do-Study-Act (PDSA) model.

Objectives of Poster:

1. Describe the gap in communication for high-risk observation.
2. Share the design and implementation of the Observation Handoff Tool.
3. Present outcomes related to staff confidence, communication, and safety.

METHODS

Setting and Participants:

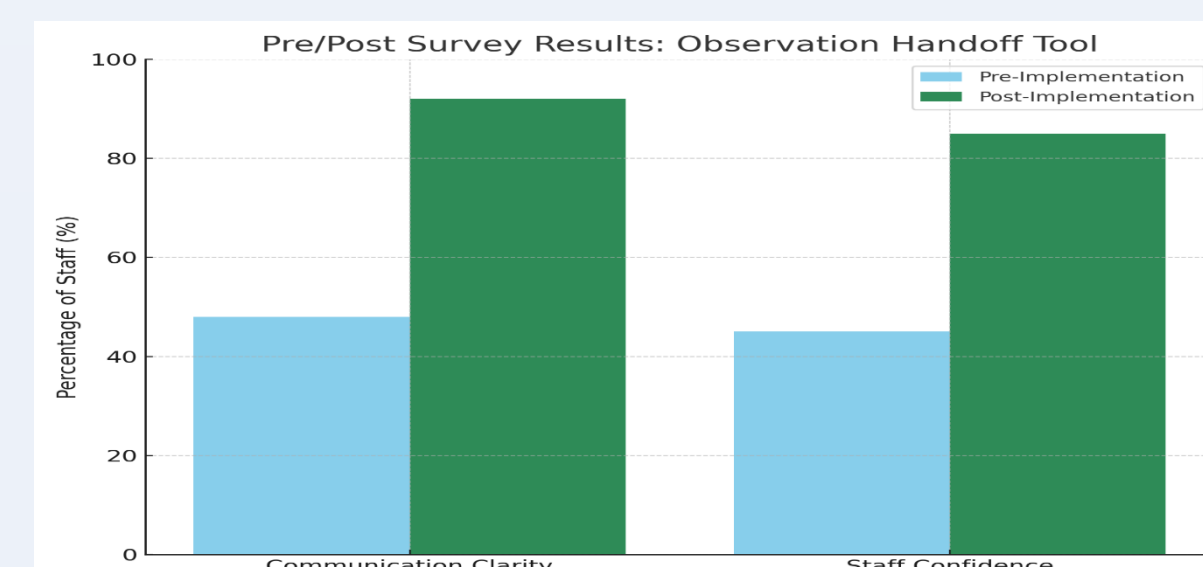
- This QI initiative was implemented on the Critical Care and Medical-Surgical units at Virtua Mount Holly. The primary participants included Direct Observers and Patient Care Technicians (PCTs)—who provide 1:1 observation for patients with behavioral health and safety risks.
- The project began in November 2024 and remains ongoing, with continuous data collection and peer coaching to support sustainability.

Intervention/Process:

- **Assessment of current state:** Staff surveys and safety reports revealed inconsistencies and missed information in verbal-only handoffs.
- **Development of a standardized tool:** A structured handoff form was created with prompts for: Known triggers and behavioral concerns, Early warning signs and De-escalations strategies and interventions.
- **Creation of a Standard Operating Procedure (SOP):** A written guide for end-users was developed to reinforce expectations and consistency in use.
- **Targeted staff education:** Observers and PCTs received training on how to complete and use the tool effectively
- **Peer coaching support:** Select staff were identified as peer coaches to model use and provide just-in-time guidance during shifts.

Data Collection and Analysis:

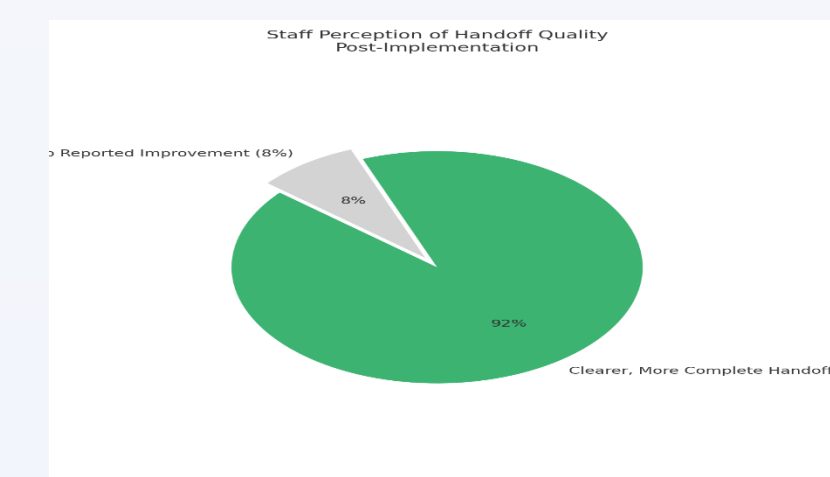
- Pre/Post-implementation surveys and incident data were analyzed to identify areas for refinement and reinforce positive outcomes.
- Qualitative feedback and safety reporting trends.



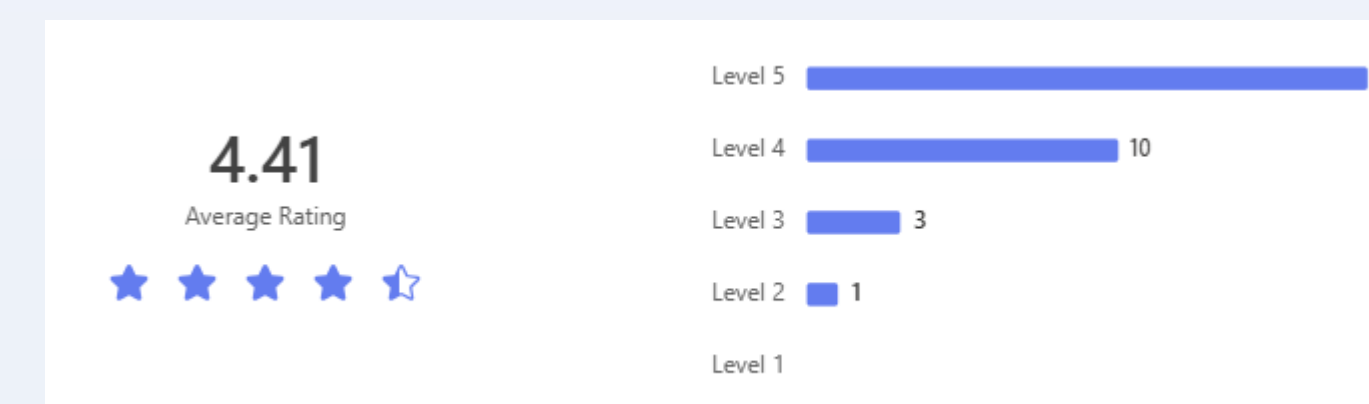
RESULTS

Key Findings:

- No safety events attributed to communication breakdown post-implementation.
- Improved handoff clarity led to greater staff confidence in managing behavioral health patients—reducing uncertainty and response time during escalations
- 92% of staff reported clearer, more complete handoffs post-implementation.



- Staff confidence increased: majority felt "comfortable" or "very confident."
- Staff confidence in performing handoffs increased significantly, with most now feeling "confident" or "very confident."
- Direct observers and PCTs rated handoff tool 4.41 out of 5.



- More structured prompts to enhance handoff quality: mobility status
- Structured tools ensure behavioral risks and de-escalation needs are not missed.

CONCLUSIONS

Interpretation:

- The results demonstrate that implementing the Observation Handoff Tool significantly advanced the primary goals of this quality improvement initiative: improving communication clarity, increasing staff confidence, and reducing safety risks during 1:1 observation handoffs.

Relevance:

- The tool improves observer practice by standardizing handoff communication, reducing safety events, and increasing staff confidence. For patients, it promotes safer care, reduces risk of incidents, and ensures more consistent, informed observation.

Limitations and Future Directions:

- **Inconsistent early use** of the tool highlighted the need for reinforced education and peer coaching.
- **Short follow-up duration** restricted analysis of long-term outcomes and behavior change.

REFERENCES

- Hawley, P., Holst, R., Bredlow, J., & Nichols, T. (2023). Development of a communication tool for handoffs involving patients cared for by sitters: An evidence-based practice project. *Journal of Patient Safety and Risk Management*, 29(1), 17–23. <https://doi.org/10.1177/107845352202900104>
- Abela-Dimech, F., & Vuksic, O. (2024). Improving the practice of handover for psychiatric inpatient nursing staff: A quality improvement project. *Archives of Psychiatric Nursing*, 38(5), 729–736. <https://doi.org/10.1016/j.apnu.2024.05.003>

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