

Improving Organizational Culture through Standardization and Expansion of Remote Handover

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Introduction

Nurse handovers are crucial elements in ensuring the continuity of nursing care and patient safety by providing guidance and focus on nursing activities during working hours. In the case of specialized nursing units, there are two types of handovers: within the ward and with other departments. While some wards, like the Neurosurgery Ward have been conducting remote handovers since 2020, the lack of standardized guidelines has led to conflicts, duplicate records, and variations in handover practices. This activity aims to create structured handover forms and guidelines to reduce discrepancies among handovers, minimize errors in communication, prevent conflicts among staff, and enhance patient safety. Additionally, the Cardiothoracic Surgery Ward which previously relied on verbal handovers has attempted remote handovers to shorten handover times, reduce conflicts, and improve staff satisfaction and organizational culture. In the case of the Intensive Care Unit-Ward handover, which accounts for the largest proportion of handovers with other wards, it is carried out through phone handover. However there is a large variation depending on the handover and the process of arranging duplicate contents back in the ward. Since a lot of time is spent in the hospital, we also want to simplify the handover between the Intensive Care Unit and the ward to shorten the handover time and allow more time to be spent on patient care.

Method

We analyzed the cases of handover. Face-to-face and non-standardized remote handovers have resulted in delays, overtime, and conflicts among staff. A pre-survey of staff satisfaction related to handovers was conducted, and handover forms from each ward were compiled and reviewed to create a standardized remote handover form. Through collaboration with other departments (Intensive Care Unit), handovers were simplified. The Cardiothoracic Surgery Ward transitioned from face-to-face to remote handovers, and post-handover satisfaction surveys were conducted for further modifications.



Result

Remote handover guidelines are still under revision, and the standardized handover form has been completed and shared, achieving a usage rate of 100%. Handover forms between the Intensive Care Unit and the Ward were standardized, and handovers with the Recovery Room were simplified. Despite implementing 100% remote handovers in the Cardiothoracic Surgery Ward there was a decrease in satisfaction related to handovers.

Conclusion

The activity identified issues with the existing handover methods. Standardized remote handover forms were created for the ward that previously conducted non-standardized remote handovers, aiming for efficient handovers. Standardized forms were shared between the ward and the Intensive Care Unit, reducing redundant tasks. While satisfaction scores did not differ for the ward continuing face-to-face handovers, they decreased from 6.2 to 5.5 for the ward transitioning from face-to-face to remote handovers. This indicates insufficient education on remote handovers and a lack of consideration for departmental characteristics during the transition. Future strategies involve ongoing monitoring, modifications to standardized handovers, and consistent training for new and transferred nurses through education specialists and preceptors to maintain an efficient handover system.

Key Metrics		Targets		Results
Establishment of remote handover guidelines	→	Complete	→	Hanover guidelines being revised
Prepare a standardized handover form	→	Complete	→	Complete
Usage rate of standardized handover form	→	Achieved 90% or more	→	Usage rate 100%
Standardization and simplification of Intensive care unit-ward handover	→	Complete	→	Complete
Remote handover execution rate in the cardiothoracic surgery ward	→	Achieved 30% or more	→	Remote handover execution rate 100%
Improved job satisfaction related to handover	→	Positive response rate 90% or more	→	Satisfaction score decrease