PATIENT SAFETY

The role of unlicensed assistive personnel in patient handoff

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HANDOFF COMMUNICATION is a critical component to ensure that accurate information about a patient’s clinical status, care plan, and treatment is transferred in a timely manner. The handoff occurs in all healthcare settings.

This article describes a research project conducted by the authors to determine if handoff communication received by nursing students working in the role of unlicensed assistive personnel (UAP) provided the necessary patient-care information to ensure safe, quality care. It starts by exploring the importance of handoff, particularly for patient safety.

Critical role of handoff

Handoff communication is defined by The Joint Commission as a process in which information about patient care is communicated consistently.1 Handoff communication takes place between clinicians to report all relevant patient-care information to the assigned nurse. The report should include all members of the healthcare team who are responsible for direct patient care.

Handoff communication is traditionally a face-to-face report between clinicians that includes patient information related to health history, current clinical status, and medical and surgical treatments. Other options for report include written, audio, or computerized report.2 Various terms used for this critical communication process include handoff, sign-out, signoff, change-of-shift report, and shift report.3

The Joint Commission reports communication breakdown is a major factor in nearly 70% of adverse medical events.4 Communication breakdowns result in patient falls, medication errors, aspiration, and pressure injuries.4

Need for change

Barriers to effective handoff communications have been identified in the literature by Riesenberg, Leitzsch, and Cunningham.5 These barriers include the following:

- ineffective communication
- lack of standardization
- equipment issues (such as with audio recordings or computer access)
- environmental issues (such as interruptions and distractions)
- lack or misuse of time
- difficulties related to complexity of patients (such as increasing acuity and volume of patients)
- lack of training or education
- human factors.

The Joint Commission has called for the development of structured handoffs for licensed nursing personnel but hasn’t identified a specific need for a structured handoff to address UAP or ancillary staff.4

Communication breakdowns can result in patient falls, medication errors, aspiration, and pressure injuries.

Many forms

Handoff communication can occur in an individualized or group context. Individualized report is when the receiving nurse obtains report on his or her patients from the outgoing nurse. Group report includes nurses and UAP. Structured tools have been identified as an important aspect to ensure that the necessary information is communicated to the appropriate healthcare personnel.5

Interprofessional collaboration refers to the coordination of patient care provided by a diverse group of healthcare providers. UAP (nursing assistants, certified nursing assistants, patient-care technicians, and orderlies) play a vital role in patient care. UAP provide direct care to patients related to personal hygiene, vital signs, feeding, ambulation, and toileting, and monitor patients’ blood glucose and cognition.6 UAP reorient and redirect patients with cognitive impairment.
The UAP role is commonly filled by nursing students who want to gain patient-care experience and increase clinical confidence with basic skills. As novices in the role, nursing students working in the role of UAP must receive report related to the components of patient care.

To address concerns about UAP receiving handoff communication and gather more information on this topic, four nursing students and their faculty member decided to perform a study.

**Literature review**

After a review of the literature, no studies evaluating handoff communication related to the UAP role were found. The Joint Commission Targeted Solutions Tool for Handoff Communications addressed ED-to-unit and unit-to-skilled nursing facility handoff communications. However, the tool didn’t include daily handoff communication to UAP. The literature related to Communication breakdown is a major factor in nearly 70% of adverse medical events.

handoff communication continues to focus on professional (licensed) nursing staff and omits the need for improved communication to ancillary staff caring for patients.

**Study’s goals**

The study described here was implemented by four senior-level nursing students under the guidance of a nursing faculty member. The purpose of this research was to determine if handoff communication received by nursing students working in the role of UAP provided the necessary patient-care information to ensure safe, quality care.

In accordance with the Nurse of the Future Core Competencies and The Joint Commission National Patient Safety Goals, this study was an effort to evaluate the type of handoff communication that currently exists in various patient-care settings and document UAP perceptions of patient-care information needed to provide safe, quality care. The goal of the research was to identify the patient information needed to serve as a template for UAP handoff communication.

**Methods**

After institutional review board approval was obtained, nursing students were invited to participate in the online study. Inclusion criteria were students who had completed their first med-surg clinical experience of 120 clinical hours. The students were informed of the study in various classes via an announcement by the investigators; information related to the study appeared in the online weekly nursing newsletter. Participation was voluntary.

Students were invited to access the online Qualtrics, a survey and data analysis tool, which consisted of 13 questions related to employment as UAP and handoff communication. Consent was assumed with the completion of the survey. Individual participant responses remained confidential. No follow-up was made with individuals participating in the study.

**Results**

Sixty-four nursing students employed as UAP participated in the study. The average years of experience as UAP was 1.45. Of the 64 respondents, 81% worked in an acute care facility, 8% worked in a subacute care facility, and 11% worked in a long-term rehab setting. Most participants received their training from their nursing
program curriculum. Most participants worked an average of one to two shifts per week and cared for an average of seven to nine patients. (See Average number of patients per 8-hour shift as UAP.) When asked if they receive handoff communication for their patients before providing care, 81% of UAP answered “yes” and 19% said “no.” A near-equal response was obtained from UAP who received report from licensed versus non-licensed staff, and handoff communication occurred at the start of their shift.

Regardless of whether they received handoff communication about their patients, UAP were asked to rank the order of importance of information they believed they needed to care for their patients. Patient medical diagnosis was identified as the most important information needed for the UAP to provide care. Other information considered critically important to handoff was cognitive status, ambulation status, fall risk, and code status.

Dietary restrictions, language barriers, skin integrity, vital signs, glucose testing, procedures, and discharge planning were viewed as helpful but not vital to patient care by UAP.

**Discussion**
The study results identified lack of experience, limited training, increased patient-care assignments, and variability in report to be key factors in delivery of patient care. These factors have the potential to impact the quality and safety of patient care delivered by UAP.

- **Lack of UAP experience.** Fifty-eight percent of participants had less than a year of UAP experience and only 3% to 5% had over 3 years of experience, raising concerns about patient safety. Providing a consistent method of report and patient-care protocols to UAP with minimal experience would enhance patient safety. Except for the nurse, UAP have the most frequent interactions with patients during caregiving. UAP must have access to the experienced nurse and receive report in a timely manner. All patient-care facilities (including long-term, acute, and rehab settings) should consider team huddles to ensure that UAP are supported during their shift and have an opportunity to review the patient’s status.

- **Limited training.** Nursing students receive variable training during their college curriculum. Typically, nursing students are eligible to work in the role of UAP after their first clinical rotation. UAP need to be proficient in tasks such as personal care, vital signs, finger-stick blood glucose testing, and intake and output. As seen in the results, 81% of respondents work in an acute care facility. With an increase in patient acuity, UAP need to have a report with the primary nurse and scheduled huddles during the shift to ensure that patients are receiving the care needed.

- **Patient assignment.** Another concerning statistic from the study was how many patients UAP are caring for during the shift. About 80% of respondents stated that they cared for a minimum of seven patients during their shift. With the increased number of patients and increased patient acuity, an accurate reporting system is needed to ensure patient safety.

- **Variability of report.** The results of this study confirmed variability in the handoff communication the UAP receive in a clinical setting. One-fifth of study participants stated that they’d received no handoff communication, placing patients in a vulnerable situation. About half of the respondents who did receive handoff communication reported that the critical patient information was received from the UAP caring for the patient. With the potential for limited training and experience, receiving report from an unlicensed staff member places the patient at risk for an adverse medical event.

- **Information needed.** When respondents identified key patient-care information needed to provide care, they didn’t identify dietary restrictions, language barriers, and skin integrity as critical information. This finding could be the result of a lack of training or experience in caring for patients.

**Conclusions and recommendations**
A consistent method of handoff communication for UAP is important to ensure quality patient care. Ideally, in acute-care settings, the RN assigned to the patient is involved in handoff communication and supports UAP to prioritize care and identify changes in a patient’s clinical status. Besides the patient’s name and room number, the UAP handoff communication needs to include the patient’s medical diagnosis, cognitive status, ambulatory status, fall risk, dietary restrictions, language barriers, skin integrity, and code status.

The RN, when making the assignment, needs to know UAP competencies related to the patient-care tasks. Additionally, the primary
nurse needs to be aware of the number of patients assigned to the unlicensed caregiver, who can benefit from frequent communication during the shift to ensure quality care.

Because this study is an initial attempt to determine the current status of handoff communication related to UAP, more research is needed to determine the necessary handoff communication information for UAP in providing safe care. Additional work related to the development of a UAP handoff communication template is needed to ensure that critical patient-care information is transferred to all members of the healthcare team. Taking these steps can help promote quality patient care and can potentially decrease adverse medical events.

REFERENCES


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The authors have disclosed no financial relationships related to this article.

DOI:10.1097/01.NURS.0000512885.29505.73