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Best Practices for Nurse-to-Nurse Handoffs

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Nursing handoffs significantly impact the outcome of patients in a health care facility with The Joint Commission finding that 60 percent of 2000 analyzed sentinel events were primarily caused by miscommunication.[1] Most common factors leading to miscommunications are a lack of time, noise and interruptions, and lack of patient engagement. These items affect the quality of the handoff, leading to incorrect or insufficient information shared from nurse to nurse.[2] This increases the risk for medication errors, falls, delayed treatment and death, which ultimately affects patient safety as well as the facility's bottom line.

The current format of nurse-to-nurse handoffs varies widely. Handoffs occur in different settings, with different tools and focuses. Not only are there differences between departments, there are differences amongst nurses within departments. Handoffs may take place in or out of the patient's room and an electronic health record (EHR) is used in some cases but not in others. Also, information shared in each handoff is inconsistent which may lead to low quality exchanges. Overall, the current state of practice is that there is no consistent practice.

Evidence shows that standardization of nursing handoffs, and ensuring they are performed at the bedside, improves the quality of patient care, and increases patient and family involvement.[3] The clinical environment also positively impacts the handoff process; positive relationships between staff members can ensure accountability. In addition, proper training increases overall support of standardized tool utilization.

It is commonly agreed that the standardization of handoffs improves the quality of overall patient care. The standardization of the process should include a clear method for providing handoffs, a concise and thorough tool that has been validated, and proper training. Based on these parameters, our recommendations to improve nurse-to-nurse handoffs include the implementation of bedside report, utilizing a hospital standardized electronic tool that is integrated with the hospital's EHR and implementing training for all nurses.

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Medicinal Cannabis Therapy for Chronic Neuropathic Pain: A Promising Alternative

By: Kerry Bird, Karissa Renee Chastain, Bailey Fritcher, Aimee Herrera and Faridha Salas

The United States is in the midst of an opioid crisis, with an estimated 130 deaths per day from opioid overdose.[1] This crisis has been linked to a rise in the number of opioid prescriptions for adult chronic pain patients from the late 1990's to present. As the Baby Boomer population ages, the prevalence of chronic conditions associated with chronic pain will increase significantly. In light of the potential for overdose, health care providers are beginning to look for alternative methods of chronic pain control, and one such option is medicinal cannabis. There is no current standard practice for managing chronic neuropathic pain with cannabis products.[2] Due to a dearth of conclusive data on the safety and efficacy of cannabis therapy, physicians lack definitive parameters for prescription. However, some research results indicate cannabis has a therapeutic potential.

Evidence for the effectiveness of cannabis in chronic neuropathic pain management is promising. A systematic review of randomized, double-blind controlled trials of medicinal cannabis found that patients achieved a reduction in pain level of 50% or greater as compared to placebo.[3] Another study found that participants experienced significant sustainable pain reduction over the course of a year.[4] This indicates that cannabis may be an effective method of controlling chronic neuropathic pain. However, most of the data remains statistically inconclusive regarding the efficacy of cannabis as the sole treatment, or its safety in long-term use.

There is a need for higher quality and more current evidence to incorporate medicinal cannabis as an evidence-based practice. Randomized controlled trials, as well as longitudinal studies are needed to examine the effects of cannabis over an extended period of time. While the quantity and quality of research is lacking, there is significant evidence to recommend the incorporation of medicinal cannabis as an adjunct therapy in current chronic neuropathic pain patients.

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The Use of Non-pharmacological and Pharmacological Therapies for Adolescent Depression

By: Margaret Heck, Mia Miller, Averie Newton, Morgan Pruitt and Katilin Steed

In 2017, 3.2 million adolescents had one or more debilitating depressive episodes, and this number has steadily increased over the past 2 years.[1] In addition, in young adolescents (11-15 years), 18 percent have experienced symptoms of depression as of 2019.[2] Currently, the most common forms of treatment are the use of medication, psychotherapy or a combination of both.

A universal treatment protocol for adolescents with depression has not been established. There is a wide range of current treatments for those diagnosed with adolescent depression. Factors including type of health care provider, socioeconomic status of the patient, age, gender and patient's personal choice have a large influence on the type of treatment prescribed to each individual. Therefore, a more refined treatment structure is needed.

Cognitive behavioral therapy, such as therapeutic conversation, is a common psychological method used to alleviate depressive symptoms. This helps patients by altering their thought processes to a more positive way of thinking. Pharmacological therapy uses antidepressant medications such as SSRIs and NRTIs to help modify the possible chemical imbalance present in each patient. Evidence finds that the combination of both therapies is the best choice of treatment due to targeting both the physical and psychosocial sources of behavior.

After finding that combination therapies are the most successful, our EBP team recommends initiating a checklist that will assist in earlier recognition of signs and symptoms by psychiatric nurses allowing physicians the ability to diagnose depression earlier. Rapid recognition leads to earlier diagnosis therefore increasing the number of positive patient outcomes.

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Positioning for the Second Stage of Labor: Inconsistent and Insufficient Evidence

By: Caroline Birnbaum, Tristen Hyde, Heather Laney, Mariana Riera and Uba Anaya

In the United States, nulliparous women in the second stage of labor experience high rates of instrumental and procedural deliveries such as cesarean deliveries, episiotomies and forcep and vacuum assisted-births.[1] Hospitals in the U.S. overwhelmingly use the recumbent position, with upright positioning being the less common practice. Current evidence is inconsistent and inconclusive regarding best practices when comparing the recumbent and upright positions during the second stage of labor and the incidence of instrumental and procedural interventions. However, evidence strongly suggests that maternal positioning affects the duration of the second stage of labor.

Historically and currently the recumbent position is the most commonly practiced position in hospital environments during the second stage of labor in the United States with an estimated 91 percent of mothers laboring in the recumbent position.[2] Continued adherence to recumbent birthing positions by health care professionals is likely due to lack of training, unfamiliarity with non-recumbent positioning, short-staffing, convenience for the birth attendant and ultimately, tradition. Aside from physician preference, maternal preference of recumbent positioning is also likely due to tradition and cultural preference.

The evidence supporting or disavowing the influence of maternal positioning on the incidence of invasive procedures during the second stage labor is inconsistent and inconclusive. However, upright positioning decreased the length of the second stage of labor in nulliparous women compared to those in a recumbent position. This shortened duration could reduce the need for interventions and improve the maternal birthing experience.

Ultimately, more research is needed to explore the relationship between maternal position, duration of the second stage labor and a need for instrumental and procedural delivery. In addition, more controlled studies are necessary to determine if either a recumbent or upright position results in better maternal and fetal outcomes and experiences. Until further evidence is procured, laboring mothers should be allowed to choose which position they would like to be in during the birthing process.

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