Strategies to Improve Handoffs

A handoff, or patient transition in care from one provider to another, involves the transfer of information, primary responsibility, and authority between providers. In hospitals, handoffs take place in multiple activities and locations, such as on admission, during shift and unit changes, before and after procedures, and at discharge.[i]

According to a Joint Commission evaluation of root cause analyses, communication problems caused almost 70% of sentinel events in accredited healthcare organizations.[ii] At least half of communication breakdowns take place during handoffs.[iii] Multiple handoffs of care have also been identified by the National Quality Forum as an environmental factor associated with increased risk of healthcare errors.[iv] Standardization of handoff communications is one of the Joint Commission's 2007 National Patient Safety Goals.

Gaining senior leadership support for initiatives to improve patient safety is a key factor for success. The implementation of changes and ideas must be based on a clear mandate from key leadership and other critical stakeholders. As your facility moves forward with standardizing and improving handoffs, take into consideration its culture, staff experience, and expertise. Below is a set of strategies and ideas that have been used to address handoffs and transitions in care. These ideas are not prescriptive and facilities are encouraged to assess their utility in their particular setting.

The table below provides an outline of recommended strategies to improve the handoff process. It provides a description of each strategy as well as resources to assist in developing an implementation plan.

1. Consider Different Types of Handoffs and Places Where They Occur

Detail	Resources
• Handoffs occur in and among many clinical areas and during various tasks. It is important to assess when handoffs occur and address the specific needs and information requirements of these handoffs. • Some handoff types include: o Nursing shift or unit change o Physician-Physician Report: Consults, Case Transfers, or on-call responsibility o Within or between specialty areas: Anesthesia to PACU nurse, Pre-admission Testing to Ambulatory Surgery, Radiology/Endoscopy/Labs to units o Nurse-Physician handoff to inpatient unit o Critical lab-imaging reports o Hospital transfers, Nursing home/Home health o Emergency or Crisis Interventions: Rapid Response Teams, Code Blue, Mental Health Codes, or Emergency Services o Medical School Staff: residents, interns, medical students to any provider o Other transitions in care (e.g. admission, discharge)	"Hand-offs and Transitions in Care" at http://jeny.ipro.org/showthread.php?t=488

2. Standardize Handoffs – Reduce Variation

Detail	Resources
• Conduct detailed verbal handoffs including read-back or repeat-back of handoff information and instructions. • Create a standard protocol for handoffs. • Develop a structured tool, such as a handoff checklist, detailing what should be covered in a handoff at different handoff points. The checklists may vary depending on what information is most needed to be transferred during that handoff.	"Case and Commentary: Fumbled Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=55 "A Model for Building a Standardized Hand-Off Protocol." Arora, Vineet and Julie Johnson. Joint Commission Journal on Quality and Patient Safety, November 2006, Volume 32 Number 11. "Case and Commentary: Triple Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=134

3. Map the Handoff Process

Detail	Resources
• Map the handoff process, assessing the current process and the idealized process. • Involve key staff in identifying the process. • Start small with one process on one unit and conduct small tests of change in the handoff process. • Assess what are the critical elements in that process. • Consider handoffs that incorporate non-clinical staff, such as transport staff.	"A Model for Building a Standardized Hand-Off Protocol." Arora, Vineet and Julie Johnson. Joint Commission Journal on Quality and Patient Safety, November 2006, Volume 32 Number 11. Illinois Hospital Association Handoff Collaborative

4. Employ 6 Principles of Error-Free Handoffs

Detail	Resources
• Communicate interactively, allowing and promoting questions between the giver and receiver of information. • Communicate up-to-date information regarding care, treatment, services, condition, and recent or anticipated changes. • Limit interruptions to avoid losing or skewing the information shared. • Allow sufficient time to complete the hand-off. • Require a verification process – repeat-backs or read-backs as appropriate. • Ensure the receiver of information has the opportunity to review relevant historical data, including previous care treatment protocols.	"Hand-offs and Transitions in Care" at http://jeny.ipro.org/showthread.php?t=488

5. Employ SBAR or Other Communication Checklists

Detail	Resources
• Include key information in the handout process using easy-to-remember acronyms. Educate staff on these communication mechanisms. SBAR: Situation Background Assessment Recommendation ANTICipate: Administrative New Information (Clinical Update) Tasks Illness Contingency Plans	"Hand-offs and Transitions in Care" at http://jeny.ipro.org/showthread.php?t=488 "Case and Commentary: Triple Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=134 TeamSTEPPS Tools at http://www.ahrq.gov/qual/teamstepps/

6. Manage Change-of-Shift Communications

Detail	Resources
• Overlap change-of-shift times so that incoming shifts overlap with outgoing shifts by 30 minutes. • Use a standardized change-of-shift report that is prepared by the outgoing nurse, electronically if possible. The report can contain the key information about the patient. • Reports on new patients or transferred patients are more complete. • At change of shift, both the incoming and outgoing nurses make bedside rounds on all patients, incorporating communication with the patient.	"Shifting to a Higher Standard" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm

7. Standardize the Patient Discharge Process

Detail	Resources
• Discharge summaries should be provided to patients in written form. The summaries can include the diagnosis, a summary of tests or procedures performed, medications prescribed at discharge, follow-up instructions, and potential side effects. • Involve patients and families in the discharge instructions. Address patient questions during the discharge process. • Address special circumstances for ill patients, such as arranging for follow-up visits or providing additional information.	"Case and Commentary: Discharge Fumbles" at http://www.webmm.ahrq.gov/case.aspx?caseID=84

8. Provide Clear Medication Instructions at Discharge

Detail	Resources
• Medication errors are among the most common post-discharge adverse events. • Develop clear instructions and provide key information on medications to be continued at discharge.	"Case and Commentary: Discharge Fumbles" at http://www.webmm.ahrq.gov/case.aspx?caseID=84

9. Use Briefings or Huddles

Detail	Resources
• Briefings or huddles are quick conversations among some or all unit nurses to discuss any new or transferring patients, as well as other information that may be important during the shift.	"Shifting to a Higher Standard" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm

10. Use Forms, Whiteboards, and Checklists

Detail	Resources
• Place a whiteboard in the patient's room that lists the patient's discharge plan, such as the "Ticket Home" whiteboard used by Virginia Mason Medical Center or Kaiser Permanente. The whiteboard can provide a brief overview of the patient's key information for all to see, along with daily goals, lab tests, practitioner names, and other notes. • Develop a "Trip Ticket" containing key patient information and instructions like the one used by Harbor Hospital to go with patients as they move within the hospital.	"She's got a ticket to….go home" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShesGotaTicketToGoHome "Shifting to a Higher Standard" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm

11. Use Facsimile Reports to Transfer Information to Receiving Units

Detail	Resources
• Medical staff can use fax reports to facilitate the movement of patients from one point of care in the hospital to the next. The use of faxed reports can be expanded beyond the ED to notify nurses on the receiving units in any area of the hospital that a patient is being transferred. • Establish a standard process for notifying nurses by fax that a patient is on the way. • Request input from staff on the floors in developing a fax tool that provides the necessary information. • The process of faxing reports from the ED can be expedited by printing the nursing units and their fax numbers on the back of the faxed report form. It can also be helpful to list the room numbers that make up each ward as ED nurses often do not know if "Room 428" is located in 4 West or 4 East. *[Submitted by: Scott Keech, Clinical Consulting Manager, Kaiser Permanente-Northern California Regional Office]*	"Faxed Report Form" at http://www.ihi.org/IHI/Topics/Flow/PatientFlow/Tools/FaxedReportForm.htm

12. Use Audio-Taped Handoffs

Detail	Resources
• Audio-taped handoffs have the benefit of an oral handoff without the practical constraints of meeting at a specific place or time. A nurse tapes a report 30 minutes before the shift ends. When the oncoming nurse has finished listening to the taped report, the reporter is available to answer any questions and to provide any interim updates.	"Reducing Risk During Handoffs" at http://www.rmf.harvard.edu/files/documents/Forum_V25N1.pdf

13. Use Information Technology When Available

Detail	Resources
• Information technology solutions can help facilitate the handoff process. • Automation is a tool to use during the handoff process, but it is not the only solution to apply.	"Case and Commentary: Fumbled Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=55 "Shifting to a Higher Standard" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm "Case and Commentary: Triple Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=134

14. Document Handoffs

Detail	Resources
• Record all patient contacts in the patient chart.	"Case and Commentary: Fumbled Handoff" at http://www.webmm.ahrq.gov/case.aspx?caseID=55

15. Update Policies and Procedures	
Detail	**Resources**
• Incorporate handoff responsibilities and tasks into relevant policies and procedures.	

16. Measure the Impact of Handoffs on Adverse Events	
Detail	**Resources**
• Measure the frequency with which communication issues are a factor in adverse events. Track this over time to trend how improvements in the handoff process may reduce adverse events. • Consider making handoff failures a code in adverse event tracking systems.	Illinois Hospital Association Handoff Collaborative

17. Measure Key Timeframes in the Handoff Process	
Detail	**Resources**
Some measures that have been used to time handoffs include: • Prepare: Time from arrival on unit to when the nurse receives the first patient report out. • Change: Time from the first patient report out to the last patient report out. • 1st Patient: Time it takes from arrival on the unit until the nurse physically sees their first patient.	"Shifting to a Higher Standard" at http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/ShiftingtoaHigherStandard.htm

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i . Corcoran, R. (2006, February 10). *Hand-offs and Transitions in Care*. Retrieved October 31, 2006, from Joint Effort New York at *http://jeny.ipro.org/showthread.php?t=488*.

ii. Joint Commission International Center for Patient Safety. (2006, September). Improving Handoff Communications: Meeting National Patient Safety Goal 2E. *Patient Safety Link, 2*(9). Retrieved March 28, 2007, from *http://www.jcipatientsafety.org/15427/*.

iii. Joint Commission International Center for Patient Safety. (2006, September).

iv. Joint Commission Resources. (2004). *Managing Patient Flow: Strategies and Solutions for Addressing Hospital Overcrowding.* Oakbrook Terrace, IL: Joint Commission Accreditation Healthcare Organizations.