Patient Handoffs

Joint Commission Definition

“A standardized process in which information about patient/client/resident care is communicated in a consistent fashion.”
VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.
- Signout accurately predicts fewer than half of overnight events
- The majority of written handoffs contain inaccurate clinical and management plans
- Residents overestimate quality of signout
- Multiple signout mnemonics exist
Patient Handoffs

- Minimal Literature – the first article on physician handoffs in the English literature was in 1988.
- A recent systematic review of the literature revealed only 46 relevant citations from 1988 – 2008 – most were descriptive and anecdotal.
- However, the anecdotes with respect to barriers and effective strategies are consistent across the literature.

80% of residents had training
Few described interprofessional training for improvement
Outpatient follow-up poor
ED throughput delays
58% follow standardized format
Significant variability in format, template
79% Faculty
61% of PDs
45% of Residents/Fellows

The sessions observed varied with regard to the presence and engagement of a supervising senior resident or faculty member.
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## Transition of Care Policy

### Purpose
To establish training and operational standards to ensure the quality and safety of patient care. Transitions of care (the “hand-off”) between providers are vulnerable to error, and a careful delineation of the UTHSCSA training programs' and the residents' responsibilities will help to minimize the number of errors that may occur following those transitions.

### Definitions
The “transition of care” referred to in this policy is the hand-off of responsibility for patient care between one provider to another, most commonly at the time of “check-out” to on-call teams. However, the same principles apply in other transitional settings, especially when transfers occur between levels of care (e.g., ward to or from ICU level of care), the scheduled change of providers (e.g., end-of-month team switches), or upon change of status from inpatient to outpatient or vice versa.
Policy

1. Program Directors must perform training on hand-offs up to a level of competency before residents are assigned responsibility for patient care. Multiple resources for such training are available and the mechanism of training will be deferred to the Program Director’s judgment. (2011 CPR VI.B.3)

2. Program Directors must monitor the performance of hand-offs to both ensure their ongoing performance, as well as to determine the residents’ competency for same, after initial training is done (2011 CPR VI.B.2). The mechanism for such monitoring will be deferred to the Program Director’s judgment.

3. A defined structure for the hand-off exists, and must include at least:
   a. The name of the patient, location, and a second, chart-based identifier (e.g., medical record number; last four digits of SSAN).
   b. Identification of the primary team, or attending physician.
   c. Diagnosis of the patient.
d. As necessary, the current status or condition, including code status, of the patient.

e. Pertinent clinical information deemed necessary for coverage for the patient (e.g., drug allergies, current medications, lab abnormalities, recent procedures or changes in condition, etc.)

f. Any elements that the recipient must perform (the “to-do” list).

g. As necessary, suggested actions to take in the event of a change in the clinical situation (the “if-then” list).

h. Augmentations to the above elements are encouraged, and should match the needs of the particular training program.

4. The following general guidelines should be followed:
   a. The number of hand-offs, per period of time, should be minimized as much as possible.
   
   b. Face-to-face hand-offs should occur if at all possible. If not possible, telephonic verbal hand-offs will occur but in either case a recorded hand-off document (written, or electronically displayed) will be available to the recipient. The hand-off must include an opportunity for the participants to ask and respond to questions. Ideally, hand-offs should occur without interruptions, and discreetly.

5. Participating training institutions must depict call schedules such that the current resident(s) and attendings (i.e., even the on-call teams) are visible to all members of the health care team.
Systematic Approaches to Handoffs

- **SBAR**
  - Situation, Background, Assessment, Recommendation

- **ANTICipate**
  - Admin data, New information (clinical update), Tasks (what needs to be done), Illness (is the patient ill?), Contingency planning/Code status
Patient Handoffs

Barriers to Effective Handoffs

- Communication barriers (hierarchy, language, general communication)
- Lack of standard system/requirement (no tool, no requirements, no system)
- Lack of training (training, education)
Hand-off as a Form of Communication

“When you move from right to left, you lose richness, such as physical proximity and the conscious and subconscious clues. You also lose the ability to communicate through techniques other than words such as gestures and facial expressions. The ability to change vocal inflection and timing to emphasize what you mean is also lost... Finally, the ability to answer questions in real time, are important because questions provide insight into how well the information is being understood by the listener.”

—Alistair Cockburn
“Swiss Cheese” Model of Error

Reason, BMJ, 2000
Safe and Effective Hand-offs: Other Industries

- Direct observations of hand-offs at NASA, 2 Canadian nuclear power plants, a railroad dispatch center, and an ambulance dispatch center

STRATEGIES

- Standardize - use same order or template
- Update information
- Limit interruptions
- Face to face verbal update
  - with interactive questioning
- Structure
  - Read-back to ensure accuracy

Patient Handoffs

Lapses in Communication

- Per the TJC, lapses in communication are the sole or a major contributing factor in 70% of sentinel events.
- 28% of surgical errors involved hand-offs as a major contributing factor.
- Communication problems were a major contributing factor in 26 – 31% of malpractice claims.
Patient Handoffs

Barriers to Effective Handoffs

- Missing information (omitted information, incorrect information)
- Physical barriers (lighting, location, noise, interruptions)
- Lack of time
- Difficulties due to complexity/high numbers
The strategies for effective handoffs are the mirror image of the barriers

- Standardization and Structure – Technology
- Training
- Empowered Communication
- Appropriate Setting
- Recognition of the Transfer of Responsibility and Authority
- Sufficient Time
The Ten Commandments of Effective Patient Handoffs

- Designate a quiet space where handoffs occur.
- Reduce interruptions (pages, nurses, etc). If an interruption occurs, begin the discussion of the patient over again.
- Set specific times for handoffs, which allows an overlap of the people involved.
- Use templates for sign-outs.
The Ten Commandments of Effective Patient Handoffs

- Empower givers and receivers.
- Review every patient: anticipated problems, major medical issues, to-do lists to complete (and why each item is needed). Do read-backs on all items on the to-do list.
- Be as specific as possible and use concrete language.
Patient Handoffs

The Ten Commandments of Effective Patient Handoffs

- Avoid nonstandard abbreviations.
- Use if-then scenarios (if patient reacts this way, do X; if patient reacts that way, do Y).

(based on work of V. Arora, M.D., University of Chicago)
# Transition Evaluation Form

Observer: ______________________

Date: ______________________  Time: ______________________

Service: ____________________

Participants:

Sender: ______________________  Recipient: ______________________

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<tr>
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<th>Adequate</th>
<th>Inadequate</th>
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<tbody>
<tr>
<td><strong>Structure</strong></td>
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<tr>
<td>Clarity of patient presentation</td>
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<td>Clarity of safety concerns</td>
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<td>Clarity of actions that are required</td>
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<tr>
<td>Clarity of residents and faculty who are on-call</td>
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<td>Clarity of care plan</td>
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<tr>
<td>Recipient was able to express questions/concerns</td>
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<tr>
<th><strong>Length</strong></th>
<th>Appropriate</th>
<th>Too Short</th>
<th>Too Long</th>
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Comments:
TOC POLICY

- Template – verbal, written, electronic
- Supervision
- Documentation of competency
- New Innovations
QUESTIONS