Patient handoffs, also known as handovers or patient care transitions, are a crucial component of quality healthcare. But too often and too easily, as patients move from one caregiver to another or one department to another, many factors can disrupt the process and put their safety at risk.

If your healthcare organization has questions about the handoff communication process, or wants to develop a standardized approach, Handoff Communication, Global Edition: Safe Transitions in Patient Care has the answers.

Tailored to the patient safety needs of international healthcare professionals, this valuable and easy-to-read guide offers:

- Content focused toward international readers
- Field-tested advice and examples of success
- Sample charts and figures
- Answers to frequently asked questions
- Case studies of successful handoff process implementation
- Downloadable forms that can be customized to suit any facility

Handoff Communication, Global Edition also features a foreword written by Thanasekaran Sinnathamby, MD, group vice president of quality and chief medical officer at Singapore-based Parkway Hospitals. The foreword touches on one hospital system’s efforts to improve handoff communication.
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CHAPTER ONE

THE HANDOFF COMMUNICATION GOAL

WHAT IS A HANDOFF?

A handoff, also known as a “handover” or “patient care transfer,” is an interactive process of transferring patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient’s care.1

Handoff communication

Handoff communication is a Joint Commission National Patient Safety Goal (NPSG) for hospitals in the United States that went into effect in 2006. It is a focus area for Joint Commission surveyors during all of their visits to accredited healthcare organizations in the United States.

Handoff communication is not yet an international safety goal for Joint Commission International (JCI). However, although the JCI has not yet required the development of a patient care handover process in its safety goals, clearly there is an international impetus to initiate improved handover communication as a patient safety strategy.
For example, handoff communication is a focus of attention for the World Health Organization (WHO). The WHO, in collaboration with the Commonwealth Fund, has created the High 5’s Project designed to create solutions for five communications-based patient care issues—one of which is handover communication. (The other four focus areas are prevention of wrong-site surgery, continuity medication errors, high-concentration medication errors, and hand hygiene.)

The WHO’s international effort will enlist a lead technical agency within each participating nation and 10 hospitals from each nation to develop prevention strategies and solutions. Later on, the knowledge gained from the collaboration will be shared with other nations and their hospitals.

**Language of the goal**

**The rationale**

To develop and implement an effective handoff communication policy, it’s important to understand the rationale for doing so. The Joint Commission’s standards format includes a statement of rationale for most standards and NPSGs to help explain why a standard or safety goal exists. The Joint Commission International would probably use a similar format when adopting an International Patient Safety Goal (IPSG) devoted to handoff communication.

The rationale for The Joint Commission’s NPSG for handoffs states: “The primary objective of a ‘handoff’ is to provide accurate information about a patient’s/
client’s/resident’s care, treatment and services, current condition, and any recent or anticipated changes. The information communicated during a handoff must be accurate in order to meet patient safety goals.”

There are many kinds of patient handoffs, including nursing shift changes; physicians transferring responsibility for a patient; physicians transferring on-call responsibility; temporary responsibility for staff leaving the unit for a short time; anesthesiologist report to recovery room nurse, nursing and physician handoff from the emergency department to inpatient units; other hospitals, nursing homes, and home healthcare; and critical laboratory and radiology results sent to physician offices.

The requirement
As of 2006, The Joint Commission added the handoff communication expectation as a requirement under the NPSG for improving communication. The requirement specifically expects healthcare organizations to “implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions.”

The goal is applicable to, and is surveyed in, all U.S. Joint Commission full and non-full surveys of the following types of organizations:
- Ambulatory hospitals
- Assisted living facilities
- Behavioral facilities
chapter 1

- Critical access hospitals
- Home care agencies
- General Hospitals
- Laboratories
- Long-term care facilities
- Office-based surgery practices

goals of a handoff policy

- Provide handoff in the same manner each time
- Verbal, face-to-face communication
- Two-way exchange of information
- Limit distractions and interruptions

implementation expectations

The Joint Commission’s implementation expectations for handoff communication can be found in The Joint Commission’s U.S. standards manual, entitled the Comprehensive Accreditation Manual for Hospitals, and are posted on the commission’s Web site, www.jointcommission.org. According to the CAMH, effective handoff communications have the following attributes:

- They are interactive communications that allow the opportunity for questioning between the giver and receiver of patient/client/resident information.
The Handoff Communication Goal

- They include up-to-date information regarding the patient’s/client’s/resident’s care, treatment and services, condition, and any recent or anticipated changes. Interruptions are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

- They require a process for verification of information received, including repeat-back or read-back, when appropriate.

- The receiver of handoff information has an opportunity to review relevant patient historical data, including previous care, treatment, and services.

Resources

The complete rationale and NPSG language for effective handoff communication can be found in the CAMH and at The Joint Commission’s Web site. Information about all of the Joint Commission’s National Patient Safety Goals for each accredited program can be found at the Joint Commission Web site. Go to www.jointcommission.org, click on “Patient Safety,” and scroll down to reach the “National Patient Safety Goals” section.

Interpreting the goal

Healthcare organizations in the United States quite often want to know exactly where and when certain NPSGs apply. Staff members involved in planning out the implementation often seek advice from The Joint Commission on what they
“have to do in order to be compliant.” System planners and designers often worry about failure in their compliance effort.

However, everyone can probably see the importance of effective handoff communication at the change of shift on a patient care unit. When everyone has reached that baseline understanding, people will begin to question what The Joint Commission and its surveyors will expect to see.

**Common questions**

Questions I’m often asked include the following:

- Do we have to do this between nursing and radiology?

- Do we have to do this between the operating room and the post-anesthesia care unit?

- Does the information exchange have to be as comprehensive as SBAR (situation-background-assessment-recommendation), or can it be less comprehensive?

The best advice is to avoid viewing the handoff communication safety goal as a compliance exercise. The goal, like other NPSGs (and IPSGs), is intended to promote better, safer care.
Internationally, JCI-accredited healthcare organizations actually have an advantage here, because they can create and implement a handover process that makes good sense to them without having to be concerned about specifics of a scoreable standard or safety goal. Now is an excellent time to begin.

To start the process, ask your staff: “Where and when should we do this in order to promote safer care?” If you can see the potential for error as the responsibility for a patient moves from one department to another, one shift to another, or one physician to another, then implement your handoff process in each setting where you see risk and potential benefit.

Here’s another question I’m frequently asked:

- What is the minimum documentation we must have in order to prove that we are compliant with the goal?

Again, the internationally accredited hospital has an advantage because you don’t need to view this as a compliance exercise. Think of your leadership role in your hospital, and consider your role in committing your organization to the improved handoff communication effort.

Your hospital should think through the different methods of documentation and different techniques that might be employed, and use the one that will work best for your organization.
THREE PHASES OF THE HANDOFF PROCESS

1. Exchanging information
2. Transferring responsibility of care
3. Providing continuity of care by preparing the team taking over so they’re able to anticipate and make timely decisions

Meeting the goal

Some organizations have used white boards in the patient rooms and “walking handoffs,” during which the process is discussed in the room, in conjunction with the patient. This is clearly a useful system—it incorporates patient involvement, and the visual aspect of seeing the patient while receiving the information may aid staff in remembering key facts.

These white boards get erased, however, when patients leave the hospital, and compliance staff can become anxious that they won’t have documentation for the JCI or another agency. Don’t worry about this because you will have successfully demonstrated compliance with the goal

• if you can demonstrate your process,
• if surveyors can observe it being done, and
• if staff can describe the process uniformly.

You don’t need to point surveyors to a specific and historical chart form. You just need to have a credible process that is effective and that all of your staff actually use.
Handoffs can occur in many places. There is almost no limit to their type. Here are some examples:

- Nursing shift changes
- Physician shift changes
- Physicians transferring on-call coverage
- Occupational, respiratory, or physical therapy
- Staff leaving the unit for a short time period, such as a meal break
- Technician shift change
- Anesthesiologist report to post-anesthesia care unit nurse
- Nurse-to-physician handoff from the emergency department to inpatient units, to another hospital, to home care, etc.
- Cross-coverage when patient acuity level changes
- Critical laboratory and radiology results sent to physician offices
- Transfer between units, such as emergency department in intensive care unit, intensive care unit to floor, labor and delivery to postpartum, etc.
- Facility transfers
- Ambulance to hospital
- Discharges home
Design considerations

You want to develop your process so that you create consistency in communication during handoffs. The process used should promote consistency of content by establishing some baseline norms. Key fields of information might include:

- admitting diagnosis
- co-morbidities
- vital signs
- allergies
- planned interventions
- issues requiring intervention by oncoming or receiving staff
- special diets

Your hospital has the opportunity to design the process and to agree on the minimum required content.

It’s important to keep in mind, however, that whatever you decide to include, the process must be applicable to each patient being handed off. Once you have determined the minimum content for the handoff, you will need to prompt staff by using a standardized form or standardized white board, such as in the example earlier in this chapter.
Dialogue

Another key part of the handoff process is dialogue—active discussion between the staff members who are departing and those who are arriving, or the sending and receiving staff.

The form or whiteboard itself does not demonstrate compliance with the goal, nor does it provide the additional safety you are striving for. Staff must be able to ask questions about the information that will be present on the form. The sending staff members’ answers to these questions provide the receiving staff with additional information they need to meet the needs of the patient.

Some organizations have sought electronic solutions to their handoff communication issues. These facilities have instituted taped change-of-shift reports, or require electronic snapshots that summarize key information about the patient. These tools by themselves, again, cannot demonstrate compliance. They only provide the capability to institute a handoff process. By themselves, they are not an acceptable handoff, but they can be incorporated into a comprehensive handover process. In the case studies section of this book, we describe one hospital that effectively implemented an electronic solution to its handover process.

Environment

In addition to providing time for active discussion between staff, it is also important for hospitals to provide an environment that is conducive to that active discussion. This means time that is interruption-free and quiet enough that each party can be heard.
Promoting the concept of active communication means staff need to feel comfortable asking questions, and the group dynamic has to support the concept that there are no stupid questions. Asking questions like, “What else can I tell you?” may help active outreach by participants and thus encourage two-way dialogue.

In addition, staff members need to object to colleagues who don’t participate appropriately or attempt to short-circuit or rush the process. The handoff communication process doesn’t work if the sending and receiving staff members don’t work as a team.

As you design your process, you must include opportunities for constructive criticism of the process, colleagues, and departments that may not be contributing as needed.

**Tips for improving handoff communication**

**Handoff communication design is not a one-person job.** The most essential concept is to involve those who will be doing the handoffs in the design of your handoff process. A department head or a performance improvement coordinator cannot design the process in a vacuum. They must involve staff in the design of the process in order to get staff buy-in, and to make sure that the design is workable. An excellent design that can’t actually be instituted is valueless.
Remember, if the JCI adopts handover communication as an IPSG, the JCI surveyors won’t just evaluate your policies and procedures—they will actually evaluate the execution of your policies and procedures.

The system must be workable. It’s also important to design a system that is practical and achievable by your staff. If you design something that requires staff to document 10 pages of information and takes an hour per patient, compliance will be nonexistent. Staff will look for shortcuts or will not follow the process at all. You can design for failure if the process is too cumbersome. Whatever you design must actually be implementable.

Pilot-test your process. A key component of the design has to be pilot-testing, which includes a phase for evaluating staff satisfaction with the new process and staff adherence to the new process. Your internal evaluation is critical before a hospitalwide launch. You don’t know whether your new process works satisfactorily until you ask staff and you look at records to see whether it is followed.
**Endnotes**

1. Thomas E. Wallace, “Preventing Fatalities—Effective Critical Communication Handoffs” (audioconference, ©2005 Joint Commission Resources Inc.).


3. Ibid, NPSG 2E.

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