The Quality Center
Patient Safety Organization

March 2018 Safe Tables:
Handoffs & Transitions of Care

Claudia Paren, MSN, RN, CPPS, CPHQ
Handoffs

- Exchange of patient care information
- Transfer of care/authority
- Complicated by physical transitions
PSO Database

- Near Miss
- Incident
- Handoff
- Shift to shift report
- Handover
- Device Event
- Med Event
- Blood Event
- Surgery Event
Common Themes

• Handoff incomplete or inaccurate
• Handoff missing/absent
• Patient arrival without notice
• Unprofessional behavior during handoff
• Documents missing after handoff
• Medication order discrepancies on discharge to SNF
**Recommendation Hierarchy**

- **Eliminate***: Eliminate the hazard/activity (e.g. asbestos/additional handoff)
- **Reduce***: Reduce the inventory (medications, radiation doses)
- **Substitute***: Use processes/methods with lower risk (e.g. MRI vs X-ray)
- **Isolate/Separate***: Segregate the hazards and the targets/receptors/people (e.g. radiation department)
- **Design***: Prevention and Recovery measures (telemetry, alarms, bar code scanners)
- **Organization***: Training, Competency, Communication
- **Procedure***: Operating procedures, Instructions, Orders, Maintenance regimes, Emergency Response procedures
- **PPE***: Personal Protective Equipment

*Administrative processes implement and maintain the effectiveness of these safeguards*
<table>
<thead>
<tr>
<th><strong>RCA²</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Stronger Actions** | New devices with usability testing  
Engineering control (forcing function)  
Simplify process  
Standardize equipment or process |
| **Intermediate Actions** | Redundancy  
Increase staffing/decrease workload  
Software enhancements, modifications  
Eliminate/reduce distractions  
Checklist/cognitive aids  
Enhanced documentation, communication |
| **Weaker Actions** | Double checks  
Warnings  
Procedure/policy  
Training |
Handoff Best Practices

• Complex problem
• Not a one-size-fits-all solution
• Evidence limited for:
  – Protocol type
  – Protocol content
  – Impact on patient outcomes (LOS, falls, adverse events, etc.)


Improvement Strategies

Steps to ensure a successful hand-off (SHARE - TST from JC):

Standardize Critical Content
Hardwire Within Your System
Allow Opportunity to Ask Questions
Reinforce Quality and Measurement
Educate and Coach
Standardize Critical Content

• Brains are powerful but limited
• We overestimate our abilities
Mnemonics/Protocols

- SBAR, ISBAR, SBAR-R
- IPASS
- ISHAPED
- RHAPP
- 5Ps
- P-VITAL
- PACE
Active Wounds

All Flowsheet Templates (all recorded)
- Height/Weight Flowsheet
- Custom Formula Data Flowsheet
- Anthropometrics Flowsheet

R - Recommendation

Priority Goals and Discharge Plan

Care Plan Problems

None

CARE HANDOFF - GO TO CHART CHECK ACTIVITY
### SBAR Communication Form

**and Progress Note for RNs/LPN/LVN**

**Before Calling the Physician / NP / PA / other Healthcare Professional:**
- **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
  - **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂ saturation and finger stick glucose for diabetics
  - **Review Record:** Recent progress notes, labs, medications, other orders
  - **Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated**
  - **Have Relevant Information Available when Reporting**
    (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

### SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are:

This started on __________ / __________ / __________. Since this started it has gotten: □ Worse □ Better □ Stayed the same

Things that make the condition or symptom worse are ____________________

Things that make the condition or symptom better are ____________________

This condition, symptom, or sign has occurred before: □ Yes □ No

Treatment for last episode (if applicable) ____________________

Other relevant information ____________________

### BACKGROUND

**Resident Description**

This resident is in the facility for: □ Long-Term Care □ Post Acute Care □ Other: ____________________

Primary diagnoses ____________________

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) ____________________

**Medication Alerts**

□ Changes in the last week (describe) ____________________

□ Resident is on (Warfarin/Coumadin) Result of last INR: __________ Date __________ / __________ / __________

□ Resident is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)

□ Resident is on: □ Hypoglycemic medication(s) / Insulin □ Digoxin ____________________

**Allergies** ____________________

**Vital Signs**

BP __________ Pulse __________ (or Apical HR __________) RR __________ Temp __________ Weight __________ lbs (date __________ / __________ / __________)

For CHF, edema, or weight loss: last weight before the current one was ____________________

Pulse Oximetry (if indicated) __________% on __________ Room Air □ O₂ __________ (__________)

Blood Sugar (Diabetic) ____________________

**Resident/Patient Name** ____________________

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### SBAR Communication Form (cont’d)

**Resident Evaluation**

Note: Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition check the box for “not clinically applicable to the change in condition being reported”.

#### 1. Mental Status Evaluation (compared to baseline; check all that apply)
- □ Decreased level of consciousness (sleepy, lethargic)
- □ New or worsened delusions or hallucinations
- □ Other (describe)
- □ Other symptoms or signs of delirium (e.g. inability to pay attention, disorganized thinking)
- □ No changes observed

Describe symptoms or signs ____________________

#### 2. Functional Status Evaluation (compared to baseline; check all that apply)
- □ Decreased mobility
- □ Swallowing difficulty
- □ Other (describe)
- □ Needs more assistance with ADLs
- □ Weakness (general)
- □ Other (describe)
- □ Falls (one or more)
- □ No changes observed

Describe symptoms or signs ____________________

#### 3. Behavioral Evaluation
- □ Danger to self or others
- □ Depression (crying, hopelessness, not eating)
- □ Suicide potential
- □ Other behavioral changes (describe)
- □ Physical aggression
- □ Other (describe)

Describe symptoms or signs ____________________

#### 4. Respiratory Evaluation
- □ Abnormal lung sounds (rattles, rhonchi, wheezing)
- □ Inability to eat or sleep due to SOB
- □ Lethargy or rapid breathing
- □ Symptoms of common cold
- □ Other respiratory changes (describe)
- □ Shortness of breath
- □ No changes observed

Describe symptoms or signs ____________________

#### 5. Cardiovascular Evaluation
- □ Chest pain/tightness
- □ Irregular pulse (new)
- □ Other (describe)
- □ Edema
- □ Resting pulse > 100 or < 50
- □ No changes observed

Describe symptoms or signs ____________________

#### 6. Abdominal / GI Evaluation
- □ Abdominal pain
- □ Abdominal tenderness
- □ Jaundice
- □ Constipation
- □ Decreased appetite/fluid intake
- □ Other (describe)
- □ Constipation (date of last BM __________ / __________)
- □ G1 bleeding (bleeding in stool or vomiting)
- □ Other (describe)
- □ Increased/absent bowel sounds
- □ Hyperactive bowel sounds
- □ No changes observed

Describe symptoms or signs ____________________

**Resident/Patient Name** ____________________
<table>
<thead>
<tr>
<th>Results</th>
<th>Number of Errors (rate per 100 patient admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRE Intervention (3510 hours)</td>
</tr>
<tr>
<td>Medical Errors</td>
<td>24.5</td>
</tr>
<tr>
<td>Injuries Causing Harm to Patients</td>
<td>4.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Balancing Measures Resident Workflow</th>
<th>% of Time per 23 hours Period Spent in Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRE Intervention (3510 hours)</td>
</tr>
<tr>
<td>Duration of Verbal Handoff/patient</td>
<td>2.4 min</td>
</tr>
</tbody>
</table>

23% Reduction
30% Reduction
No More Time
Situation Awareness & Contingency Planning

- MRN:
- DOB:
- Code Status: Full Code
- Primary Emergency Contact:
- Home Phone:

Edited by: Leziel Abenes, RN at 3/10/2018 2019

Synthesis by Receiver

- PRN Meds given: ***
- Net UF: 2.2 L (03/13/18 2000)
- Blood Products given: ***
- Follow up dressing care: ***
- Follow up concerns: ***

Reposition: Turns self
Weight Method: Bed weight
Blood Products to be transfused: ***
Labs to be drawn: ***
**Minimum Content**

<table>
<thead>
<tr>
<th>Summary of patient:</th>
<th>Action Plan</th>
<th>Nurse to nurse synthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Nursing interventions to consider</td>
<td>Restating major concerns (occurs throughout report)</td>
</tr>
<tr>
<td>Admitting diagnosis</td>
<td>Procedures/tests to do</td>
<td></td>
</tr>
<tr>
<td>Mental status</td>
<td>Discharge planning</td>
<td></td>
</tr>
<tr>
<td><strong>Code status</strong></td>
<td>Nursing interventions to monitor</td>
<td></td>
</tr>
<tr>
<td><strong>Allergies</strong></td>
<td>Patient/family education</td>
<td></td>
</tr>
<tr>
<td>Pertinent medical history</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current vital signs</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Current labs</strong></td>
<td></td>
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<tr>
<td>Pertinent physical assessment</td>
<td></td>
<td></td>
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<tr>
<td><strong>Pertinent medications</strong></td>
<td></td>
<td></td>
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<tr>
<td>Pertinent family information</td>
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<tr>
<td>Precautions</td>
<td></td>
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<tr>
<td>Lines, drains and tubes</td>
<td></td>
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<tr>
<td>ADL status</td>
<td></td>
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<tr>
<td>Ambulatory status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Joint Commission Adds:**
- Contingency planning
- Sender contact information

Hardwire

- Obtain buy-in from users
- Integrate with existing workflows and technology
- Engage the entire team, if appropriate
- Consider environment

- Beware competing priorities
Engaging Others

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less
Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Questions

http://alistair.cockburn.us/Effectiveness+of+different+modes+of+communication+graph.gif
Non-verbal Matters

What Can Senders Do?

• Utilize joint-focus (report sheet, census, pre-printed tool)

• Relevant items that will be Remembered
  – Focus on sickest patients first
  – Daily progress (today’s baseline, updated events)
  – Direction → To Do Items and If/then items

• Directions with Rationale
  – avoid ambiguity → “check CBC” without giving a reason why and what to do with results

• Check for receiver understanding
  – Encourage questions and read-back
What Can Receivers Do?

• Actively listen
  – stay focused, limit interruptions, take notes to enhance memory

• Ask questions
  – to ensure you understand directions
  – the handoff is your learning opportunity

• Use a system
  – to keep track of to do items that require your action

• Read-back
  – directions to ensure you are on the same page
Measurement

• What to measure
  – Adverse events
  – Quality/content of handoff

• When to measure
  – Periodic
  – Unscheduled
  – After orientation/on-boarding?

• Who will measure
  – Peer evaluations
  – Secret observers

• What to do with data
Measurement

<table>
<thead>
<tr>
<th>Table 1: Handoff CEX: assessment of the provider and the emission process (English version)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Setting (☐ not observed)</strong></td>
</tr>
<tr>
<td>≥5 interruptions; noisy, chaotic</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>No interruptions; silent</td>
</tr>
<tr>
<td><strong>Organization/efficiency (☐ not observed)</strong></td>
</tr>
<tr>
<td>Disorganized; Rambling</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>Standardized sign-out; concise</td>
</tr>
<tr>
<td><strong>Communication skills (☐ not observed)</strong></td>
</tr>
<tr>
<td>Not face to face; Understanding not confirmed; No time for questions; Responsibility for tasks unclear; Vague language</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>Face to face sign-out; Confirm understanding; Elicits questions; Assigns responsibility for tasks; Concrete language</td>
</tr>
<tr>
<td><strong>Content (☐ not observed)</strong></td>
</tr>
<tr>
<td>Information omitted or irrelevant; Omits clinical condition; ‘to dos’ lack plan, rationale</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>Includes all essential information describes clinical condition, ‘to dos’ have plan, rationale</td>
</tr>
<tr>
<td><strong>Clinical judgement (☐ not observed)</strong></td>
</tr>
<tr>
<td>No recognition of sick patients; No anticipatory guidance</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>Sick patients identified; Anticipatory guidance provided with plan of action</td>
</tr>
<tr>
<td><strong>Humanistic qualities/professionalism (☐ not observed)</strong></td>
</tr>
<tr>
<td>Hurried, inattentive; Inappropriate comments re: patients, family, staff</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Superior</td>
</tr>
<tr>
<td>Focused on task, appropriate comments re: patients, family, staff</td>
</tr>
<tr>
<td>Overall sign-out competence</td>
</tr>
<tr>
<td>Low</td>
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<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>High</td>
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<tr>
<td>Evaluatee satisfaction with evaluation:</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Comments:</td>
</tr>
<tr>
<td>Horwitz et al, 2013 (reproduced with permission)</td>
</tr>
</tbody>
</table>

Educate & Coach

• Train staff and new hires
• Provide real-time feedback
• Emphasize professionalism
“When it is time to handover... The incoming fresh nurse arrives. The patient folder is scrutinized with critical eyes. Tiny errors are pointed out- the nurse gives a hard stare. Minute imperfections and omissions are questioned, more hard staring... The oncoming nurse shows no mercy. It appears I have been doing nothing at all for the entire shift... This is what handover has become. Not a sharing of information but an inquisition- a time to put down the efforts of another.” (Emphasis added)

# Validated Root Causes for Transition of Care: Hand-off Communications Failures

<table>
<thead>
<tr>
<th>All participating hospitals</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture does not promote successful hand-off, e.g. lack of teamwork and respect</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations between sender and receiver differ</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Ineffective communication method, e.g. verbal, recorded, bedside, written</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Timing of physical transfer of the patient and the hand-off are not in sync</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Inadequate amount of time provided for successful hand-off</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Interruptions occur during hand-off</td>
<td>x</td>
<td></td>
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<tr>
<td>Lack of standardized procedures in conducting successful hand-off, e.g. SBAR</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Inadequate staffing at certain times of the day or week to accommodate successful hand-off</td>
<td></td>
<td>x</td>
<td>x</td>
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<tr>
<td>Patient not included during hand-off</td>
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<tr>
<td>Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/issues, contact information</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Sender, who has little knowledge of patient, is handing off patient to receiver</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Sender unable to provide up-to-date information, e.g. lab tests, radiology reports, because not available at the time of hand-off</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Sender unable to contact receiver who will be taking care of patient in a timely manner</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Inability of sender to follow up with receiver if additional information needs to be shared</td>
<td></td>
<td>x</td>
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<tr>
<td>Sender asked to repeat information that has already been shared</td>
<td>x</td>
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<tr>
<td>Receiver has competing priorities and is unable to focus on transferred patient</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Receiver unaware of patient transfer</td>
<td>x</td>
<td>x</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Inability for receiver to follow up with sender if additional information is needed</td>
<td>x</td>
<td>x</td>
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<td></td>
<td></td>
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<tr>
<td>Lack of responsiveness by receiver</td>
<td>x</td>
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<tr>
<td>Receiver has little knowledge of patient being transferred</td>
<td>x</td>
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</tr>
</tbody>
</table>

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.
Thank you!

• Please complete an evaluation.
• Check your email for CE instructions.
  Note: The CE portal will be active until March 27, 2018 at 11:59 pm ET. Please claim your certificate(s) by this date/time.
• Interested in hosting a Safe Table like today at your organization? Please let us know!