Improving Handoffs, Improving Patient Safety

October 7, 2016

Handoffs are a necessary part of patient care. These transfers of information, authority and responsibility occur whenever a provider changes, when a patient is transferred from one unit to another, before and after a procedure, and at admission and discharge.

Handoffs account for a disproportionate number of patient safety events. According to a Joint Commission analysis communication errors account for nearly 70% of sentinel events and at least half of these errors occur during handoffs.

Given the importance of this common occurrence what are some methods providers can use to improve communication during handoffs and ensure patient safety? Here are a few ideas:

1. **Determine what will trigger a handoff.** Obvious times for a handoff include a shift change or a patient move to a different unit. Other opportunities for handoffs include critical diagnostic test results, a physician to nurse handoff, whenever an event, such as the Rapid Response Team activation, occurs for a patient.
2. **Ensure adequate time for handoffs.** Time should be set aside and protected for communication of handoff information. This time should be consistent; it could be five minutes before the change of a shift, whenever a patient leaves the unit for a diagnostic study, whenever

a patient is admitted, etc. Whatever the time or triggering event chosen, it should be consistently applied.

3. **Ensure adequate space for handoffs.** Handoffs should optimally be done face-to-face, in a quiet setting that promotes giving and receiving important information. While the face-to-face handoff with written material is the gold standard, there may be times when it is not possible and other methods, such as email, texting, computer generated documents or the EHR must be used in the handoff. If this is the case, confirmation that critical information was received and understood must be obtained.
4. **Include critical data.** This may vary by practice setting but would likely include a patient summary, appraisal of illness severity, pending tests/studies/procedures, contingency plans ("if/then" statements; "if" the hemoglobin is below 7 "then" transfuse one unit of packed red blood cells). This data should be read-back by the receive to verify.
5. **Employ a communication checklist.** An example of this is SBAR: Situation, Background, Assessment and Recommendation. There are numerous others available as well. It's less important which one you use, it's more important that the participants are familiar with the checklist and use it in a consistent fashion.
6. **Establish adequate communication.** The handoff is not a one-way street. The provider who is receiving the handoff must be an active listener, willing to ask questions and be able to read-back the information given to confirm accuracy.
7. **Evaluate the Handoff process.** Periodically review the handoff process on various units. What works? What doesn't? Does the staff feel there are any additions to the handoff that would make it more effective?
8. **Standardize!** Variability in the handoff process increases the risk of miscommunication between providers which increases the risk of patient harm. All of the items above can be standardized which will not only improve the handoff but will make the handoff process more efficient.

Finally, the handoff isn't complete until it is documented. The time of the handoff, the participants and the data exchanged should all be reflected in the chart. Improving the handoff process will improve both patient care and patient safety.

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Source URL: https://www.magmutual.com/learning/article/improving-handoffs-improving-patient-safety