

INSIGHTS ON HANDOFFS: What is WORKING and where are the GLITCHES

Participants in the Handoffs and Transitions Learning Network Session I on April 19, 2007 took part in an activity designed to help them gather information on how handoffs are working in their facilities. The session was facilitated by Diane Frndak of West Penn Allegheny Health System. Participants made note of what was working and what was not working related to handoffs, and shared their insights with the group. Below is a summarized list of the comments.

	INSIGHTS/WORKING	GLITCHES/NOT WORKING
Information Availability	<ul style="list-style-type: none"> ◆ Patient information present in labs, charts, and the computer ◆ Time allotment for answering and asking questions ◆ Consultation between services to medically manage diabetes mellitus 	<ul style="list-style-type: none"> ◆ Lack of understanding among RNs and MDs of who is in charge ◆ Resident sign-off without providing pertinent information ◆ Unable to locate patient charts ◆ Sometimes reports are “scattered” and there may not be a standard ◆ Lots of variation among departments and staff within departments ◆ Narcotic policy during handoff process ◆ Interim drug availability ◆ Plan of care is unclear or poorly communicated
Patient Focus	<ul style="list-style-type: none"> ◆ Patient involvement (patient writes list of home medications) ◆ Narrative story of patient 	<ul style="list-style-type: none"> ◆ Sequential handoffs of same patient
Unit to Unit	<ul style="list-style-type: none"> ◆ Handoff from recovery room to unit ◆ Verbal reports with ICU, IMC ◆ ED to floor report via a standardized form ◆ Communication between RN & Rehab staff at transfer ◆ Process of hand-off from ED to floor – very compliant ◆ ICU transfer order form ◆ Verbal report between change in level of care 	<ul style="list-style-type: none"> ◆ ED nurse busy and does not fill out trip ticket – verbally communicates with transporters ◆ ED satellite site patients forgotten – not handed off ◆ Tension between units at points of transfer ◆ Transfer from ED to floor done rapidly, with little opportunity for follow-up questions. ◆ ED to floor – no human communication ◆ Delay of transition of patient and hand off because unable to get receiving staff to take the report ◆ Incomplete information is provided during a unit to unit handoff

	INSIGHTS/WORKING	GLITCHES/NOT WORKING
Shift to Shift	<ul style="list-style-type: none"> ◆ Face to face ◆ Single tape on every patient for shift report ◆ Shift- to-shift handoff and bedside, including “managing up” of oncoming nurse, followed by detailed report outside of patient room ◆ Recorded reports at change of shift ◆ Nurse to nurse report at bedside ◆ Nurse to nurse report often to the point and informative ◆ IT shift report form has good info for RN to RN change of shift info 	<ul style="list-style-type: none"> ◆ Shift report – format for verbal time is loose
Discharge/ Hospital Transfer		<ul style="list-style-type: none"> ◆ Poor communication from transferring hospital, including communication between the RN and MD at the receiving hospital.
SBAR	<ul style="list-style-type: none"> ◆ Unit-specific SBAR used as a guide for handoff communication ◆ SBAR Kardex patient profile 	<ul style="list-style-type: none"> ◆ Staff awareness of what SBAR stands for
Transport to Ancillary Services/Trip Ticket	<ul style="list-style-type: none"> ◆ Use trip ticket with verbal communication with transporters ◆ Ticket to Ride give appropriate info and provides patient safety ◆ Ticket to Ride – Fall risk indicated, non-verbal indicated, contact number and name of nurse ◆ Form (part of medical record) travels with patient to procedures and improves continuity of information 	<ul style="list-style-type: none"> ◆ Time needed by nurse to fill out the ticket and interruptions ◆ Transporters need education on patient identification ◆ Transporters do not notify nurse when removing patients from the area for procedures.
Verbal Reports	<ul style="list-style-type: none"> ◆ Verbal reports for coverage (lunch/breaks) ◆ Interactive (no more taping!) 	<ul style="list-style-type: none"> ◆ Verbal reports lack structure – forgotten material
Other tools/reports	<ul style="list-style-type: none"> ◆ Whiteboard with notes/patient care plan ◆ Post-event communication to address changes in patient’s status ◆ Walk–A-Rounds ◆ Fax report is good tool ◆ PI tools to evaluate ◆ Auto Kardex with populated information 	<ul style="list-style-type: none"> ◆ Isolation precautions not being communicated ◆ Lack of physician, RN rounding at bedside ◆ Walk–A-Rounds not consistent organization-wide ◆ Faxed report not as complete as person to person report ◆ Paper handover report not updated

	INSIGHTS/WORKING	GLITCHES/NOT WORKING
Environment	<ul style="list-style-type: none"> ◆ Single handoff ◆ Increasing staff awareness – they are asking for handoff 	<ul style="list-style-type: none"> ◆ Failure to ask questions ◆ Agency nurses or others not familiar with the handoff format used ◆ Multiple interruptions during important times of communication and handoff ◆ Controlling noise ◆ RN leaves before report is given ◆ Handoff conflicts with care of other patients – timing of handoff may not be convenient for RN caring for other patients ◆ Not an opportunity for recovery and questions