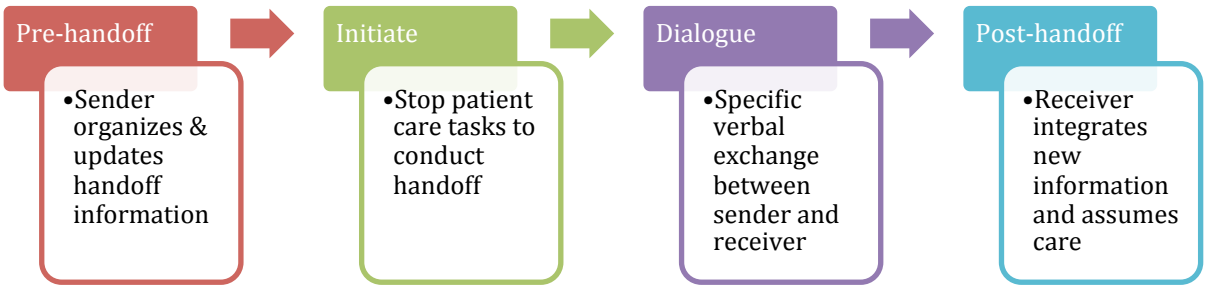
HANDOFF COMMUNICATION BEST PRACTICES

NCQC PSO Safe Table – October/November 2015

Handoffs occur throughout the healthcare system by the thousands and are critical to patient safety. However the handoff process can be highly variable and potentially unreliable, creating a high-risk area for patient safety and quality. The handoff process consists of four phases:

Handoff Process



Standardizing Handoff Communication

Since variability of handoffs can lead to increased risk and adverse events, standardization of handoff content to the clinical setting is important. This is usually done through the use of various tools (mnemonics) used for the handoff process: SBAR, IPASS the BATON, ANTICipate, SHARQ, IPASS. They serve as memory aids for a standardized process. Some of the most commonly used handoff tools are:

SBAR	IPASS	ANTICipate
– **S**ituation – **B**ackground – **A**ssessment – **R**ecommendations	– **I**llness Severity – **P**atient Summary – **A**ction List – **S**ituation Awareness & Contingency Planning – **S**ynthesis by Receiver	– **A**dministrative data – **N**ew clinical information – **T**asks to be performed – **I**llness severity – **C**ontingency plans

SBAR was developed to transfer clinical information efficiently, when time is limited and a quick decision is sought. Over the years SBAR has been extended to handoffs and has some limiting applications, especially for complex patients. I-PASS began as a research study addressing physician handoffs and has spread to nursing and other handoffs. It emphasizes situational awareness at the patient and team level and active contingency planning.

Technology can be used to standardize handoff content and improve completeness, but the balance of too much information and not enough relevant information can add to ineffective handoffs. Also very important and not to be neglected, is the behavioral and cultural aspects that can affect communication. Reframing the handoff to a team task and not just a one-way transfer of information can broaden the process to include development of a shared mental model and the ability to do cross checking.

A Key Element to Effective Handoffs: Asking Questions

The opportunity to ask questions involves critical thinking skills, sharing and receiving information as a team. Questions will vary by discipline and often fall into these categories:

- Confirming patient status, response or treatment
- Planning tasks, workflow and timing
- Consensus about clinical reasoning
- Framing and alignment

Social interaction can play a critical role in *how and what* information is shared. Coaching and mentoring and real-time feedback can underscore the importance of handoffs to patient safety and encourage better relationships and communication between staff members.

Handoff Measures

Measuring handoff quality and effectiveness depends on many dynamic aspects of the handoff.

1. Content
   - Completeness, accuracy and relevancy of information
2. Process
   - Environmental (interruptions, noise level and workload)
   - Behavioral (shared planning, decision making, critical review of care planning, acknowledgement of info received)
   - Hospital Survey on Patient Safety Culture – Handoff Dimension
3. Outcome
   - Satisfaction with handoff
   - Impact on subsequent care
   - Event Reporting

The Solutions

The Joint Commission Center for Transforming Healthcare Handoff Project lists these elements for a successful handoff:

1. Standardize critical content
2. Hardwire within your system
3. Allow opportunity to ask questions
4. Reinforce quality and measurement
5. Educate and coach
6. *Don't forget teamwork!*

Handoff Education

1. Didactic session that teaches techniques and concepts
2. Handoff simulation
3. Computer module learning
4. Resources to educate and train
5. Observation & feedback tools
6. Campaign handoff toolkit