Patient Transfers and Handoffs in Emergency Care Settings

Description

The Joint Commission recognizes that ineffective handoff communications are a critical patient safety problem in healthcare. In fact, an estimated 70% of serious medical errors are associated with high miscommunication rates during patient handoffs (Davis et al., 2021; Shahid & Thomas, 2018). The handoff, or transfer of pertinent information from one healthcare provider to another, is a fundamental aspect of communication in healthcare (Piazza et al., 2021). Handoff incorporates discussion of patient-specific information, transfer of responsibility for the patient's care, and release and assumption of the authority and accountability for treatment and procedures by the caregivers (Alimenti et al., 2019). Vital information shared during the handoff includes the patient's chief complaint or diagnosis, diagnostic test results, the care that has been provided, the patient's response to treatment, and care that has yet to be performed (Shahid et al., 2018). Patient handoffs occur several times, in multiple ways, and under various conditions each day across the continuum of patient care, from prehospital to long term care. It is likely that more handoffs occur in the emergency department than anywhere else (American Academy of Pediatrics, Committee on Pediatric Emergency Medicine et al., 2016; Campbell & Dontje, 2018).

Multiple national and international organizations have recommended that institutions implement a standardized approach to handoffs in order to improve patient safety. In 2010, the Joint Commission began requiring that accredited organizations use a standardized approach to handoff communications. Accreditation Canada (2020) requires information to be transferred whenever the patient experiences a change in caregiver or location. This includes at admission, transfer, handoff, and discharge. The required organizational plan (ROP) also requires the information shared at transfer be documented in the patient's chart, to meet legal requirements for the patient's record of care (Accreditation Canada, 2020).

ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. A standardized approach to and clear guidelines for patient handoffs improves communication and ensures safe and effective transfer of vital information.
2. Patients, families, and all levels of caregivers be given the opportunity to be involved in handoff communication and information sharing.
3. Emergency nurses and support personnel receive education and training regarding best practices for and the importance of patient handoffs.

Background

Patient safety associated with effective handoff communication is a global concern. The impact of ineffective handoffs includes such adverse events as delays in diagnosis and treatment, fragmented care, breaches in care, medication errors, conflicting communication, duplication of procedures and tests, lower provider and patient satisfaction, higher costs, longer and more frequent hospital stays, and patient deaths (Piper et al., 2018). According to The Joint Commission (2017) Provision of Care Standard PC.02.02.01, the organization's process for handoff communication provides the opportunity for discussion between the giver and receiver of patient information. Recognizing handoffs as a critical patient safety issue, The Joint Commission teamed with a group of U.S. hospitals and healthcare systems through its Center for

Transforming Healthcare to explore the use of new methods to reduce dangerous and potentially deadly breakdowns in patient care (Joint Commission Center for Transforming Healthcare, 2010).

The Situation, Background, Assessment and Recommendations (SBAR) format is used to facilitate prompt, appropriate communication and patient safety. In the United States, The Joint Commission, Agency for Healthcare Research and Quality (AHRQ), and the Institute for Health Care Improvement (IHI) recognize SBAR as an effective communication tool for patient handoffs (Shahid & Thomas, 2018). SBAR is used in the United Kingdom, where communication failures are identified as a prime cause of patient safety incidents in the inpatient setting. In a medical emergency, patient survival often depends on inpatient staff making an early and effective call for help (Featherstone et al., 2008). Internationally, Accreditation Canada, the Australian Commission for Safety and Quality in Health Care (AHSQHC), and the World Health Organization (WHO) also recognize SBAR as an effective patient safety communication tool (Shahid & Thomas, 2018).

Other standardized formats intended to optimize patient outcomes by improving communication and teamwork include Team Strategies and Tools to Enhance Performance and Patient Safety (Team STEPPS) and Illness Severity, Patient Summary, Action List, Situation Awareness and Synthesis by Receiver (I-PASS). These systems and processes are identified in the literature as standardized patient handoff and transfer methods that reduce risks to patients (Nwaukwa &Satyshur, 2021; Starmer et al., 2017; Joint Commission Center for Transforming Healthcare, 2010). In Canada, where there is a universal healthcare system, initiatives can be aligned provincially or within designated health regions. For example, in Alberta Identify patient, Diagnosis and/or current problem, Recent changes, Anticipated changes, and What to watch for (IDRAW) is used, along with SBAR (Accreditation Canada, 2020). The Australian Commission for Safety and Quality in Health Care (2009), recommends Introduction, Situation, Background, Assessment and Recommendation (ISBAR). This tool is used as a shared mental model for transfer of relevant information between care providers. To improve communication and provide a structured format the Reason-Story-Vital Signs-Plan initialism (RSVP) is easy to remember in an emergency and includes the essential information (Featherstone, et al. 2008). According to Featherstone (2008), the use of such a structured call for help could improve patient safety.

The increasing use of electronic health records (EHR) and other similar technologies can enhance hand-offs, but they are not a substitute for effective communication (Accreditation Canada, 2020; Jewell & Committee on Hospital Care, 2016; The Joint Commission, 2012). Some authors have described the benefits of report at the bedside and demonstrated that education and the use of standardized guidelines and processes reduced errors and improved critical care patient outcomes (Benjamin et al., 2016; Chang et al., 2010). Additional studies are necessary to establish practices that will improve the process of safely transitioning the patient through the many levels of providers in the healthcare continuum (Nwaukwa & Satyshur, 2021; Piper et al., 2018).

Resources

Accreditation Canada. (2020). *Required organizational practices: Information transfer at care transitions* https://src.healthpei.ca/sites/src.healthpei.ca/files/Accreditation/Accreditation_Canada_Required_Organizational_Practices_Handbook.pdf

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of

Emergency Physicians, Pediatric Emergency Medicine Committee, & Emergency Nurses Association Pediatric Committee. (2016). Handoffs: Transitions of care for children in the emergency department. *Pediatrics*, *138*(5), Article e20162680. https://doi.org/10.1542/peds.2016-2680

Australian Commission for Safety and Quality in Health Care. (2009). *ISBAR revisited: Identifying and solving barriers to effective clinical handover – Project toolkit*. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/isbar-revisited-identifying-and-solving-barriers-effective-clinical-handover-project-toolkit

Island Health. (2016, February 26). *IDRAW – Information transfer and communication at handovers*. https://vicsi-ltci.ca/wp-content/uploads/2019/12/idraw-information-transfer-communication-handovers.pdf

The Joint Commission. (n.d.) *Handoff communications targeted solutions tool*. https://www.centerfortransforminghealthcare.org/products-and-services/targeted-solutions-tool/hand-off-communications-tst/

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2019, September 7). *Handoffs and signouts*. https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts

References

Accreditation Canada. (2020*). Required organizational practices: Information transfer at care transitions.* https://src.healthpei.ca/sites/src.healthpei.ca/files/Accreditation/Accreditation_Canada_Required_Organizational_Practices_Handbook.pdf

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Emergency Medicine Committee, & Emergency Nurses Association Pediatric Committee. (2016). Handoffs: Transitions of care for children in the emergency department. *Pediatrics*, *138*(5), Article e20162680. https://doi.org/10.1542/peds.2016-2680

Alimenti, D., Buydos, S., Cunliffe, L., & Hunt, A. (2019). Improving perceptions of patient safety through standardizing handoffs from the emergency department to the inpatient setting: A systematic review. *Journal of the American Association of Nurse Practitioners*, *31*(6), 354–363. https://doi.org/10.1097/JXX.0000000000000160

Australian Commission for Safety and Quality in Health Care. (2009). *ISBAR revisited: Identifying and solving barriers to effective clinical handover – Project toolkit*. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/isbar-revisited-identifying-and-solving-barriers-effective-clinical-handover-project-toolkit

Benjamin, M., Hargrave S, & Nether, K. (2016). Using the Targeted Solutions Tool® to improve emergency department handoffs in a community hospital. *The Joint Commission Journal on Quality and Patient Safety*, *42*(3),107–114. https://doi.org/10.1016/s1553-7250(16)42013-1

Campbell, D., & Dontje, K. (2018). Implementing bedside handoff in the emergency department: A practice improvement project. *Journal of Emergency Nursing*, *45*(2) 149–154.

https://doi.org/10.1016/j.jen.2018.09.007

Chang, Y. N., Lin, L. H., Chen, W. H., Liao, H. Y., Hu, P. H., Chen, S. F., Peng, & Y. C. (2010). Quality control work group focusing on practical guidelines for improving safety of critically ill patient transportation in the emergency department. *Journal of Emergency Nursing*, *36*(2), 140ξ145. https://doi.org/10.1016/j.jen.2009.07.019

Davis, J., Allen, S., & Forshey, M. (2021). Handoff communication: Case for flexible standardization, *Journal of Patient Safety*, *17*(1), e39–e40. https://doi.org/10.1097/PTS.0000000000000745

Featherstone, P. I., Chalmers, T., & Smith, G. B. (2008). RSVP: A system for communicating patient deterioration in hospital patients. *British Journal of Nursing*, *17*, 860–864. https://doi.org/10.12968/bjon.2008.17.13.30540

Institute for Health Care improvement., (2016, April 13). *SBAR Tool: Situation-background-assessment-recommendation*. http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx.

Jewell, J. A., & Committee on Hospital Care. (2016). Standardization of inpatient handoff communication. *Pediatrics*, *138*(5), e20162681. https://doi.org/10.1542/peds.2016-2681

Joint Commission Center for Transforming Healthcare. (2010, October 21). *Joint Commission Center for Transforming Healthcare tackles miscommunication among caregivers.* http://www.pwrnewmedia.com/2010/jointcommission_01021_miscommunication/index.html

Nwaukwa, S., & Satyshur, R. (2021). Implementation and evaluation of a patient handoff tool to improve nurse to nurse communication. *Journal of the American Medical Directors Association*, *22*(3) B13. https://doi.org/10.1016/j.jamda.2021.01.029

Piazza, A. J., Brozanski, B., Grover, T., Chuo, J., Mingrone, T., Rao, R., Smith, J., Soliman, D., Rintoul, N., Bellflower, B., Richardson, T., Holston, M., McClead, R., Guidash, J., & Pallotto, E. K. (2021). STEPP IN: A multicenter quality improvement collaborative standardizing postoperative handoffs. *Pediatrics*, *148*(6), Article e2020016402. https://doi.org/10.1542/peds.2020-016402

Piper, D., Lea, J., Woods, C., & Parker, V. (2018). The impact of patient safety culture on handover in rural health facilities. *BMC Health Services Research*, *18*, Article 889. https://doi.org/10.1186/s12913-018-3708-3

Shahid, S., & Thomas, S. (2018). Situation, Background, Assessment, Recommendation (SBAR) communication tool for handoff in healthcare –A narrative review. *Safety in Health*, *4*, Article 7. https://doi.org/10.1186/s40886-018-0073-1

Starmer, A. J., Schnock, K. O., Lyons, A., Hehn, R. S., Graham, D. A., Keohane, C., & Landrigan, C. P. (2017). Effects of the I-PASS nursing handoff bundle on communication quality and workflow. *BMJ Quality and Safety*, *26*(12), 949–957. http://doi.org/10.1136/bmjqs-2016-006224

The Joint Commission. (2017). Inadequate hand-off communication. *Sentinel Event Alert* (58). https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication

The Joint Commission. (2012). Joint Commission Center for Transforming Healthcare releases targeted solutions tool for hand-off communications. *Joint Commission Perspectives*, *32*(8), 1, 3.

Authors

Authored by

Dawn Peta, BN, RN, ENC(C)

Reviewed by

2022 ENA Position Statement Committee
Brenda Braun, MSN, BSN, RN, CEN, CPEN, FAEN
Alison Day, PhD, MSN, BS, RN, FAEN
Lisa Leiding, DNP, RN, CCHP-RN
Joanne Navarroli, MSN, BS, RN, CEN
Cheryl Riwitis, DNP, RN, FNP, EMT-B, CEN, CFRN, FNP-BC, TCRN, FAEN
Elizabeth Stone, PhD, RN, CPEN, CHSE, FAEN
Sharon Vanairsdale, DNP, MS, RN, APRN, NP, CNS, CEN, ACNS-BC, NP-C, FAEN, FAAN
Jean Proehl, MN, RN, CEN, CPEN, TCRN, FAEN, FAAN, Chairperson
ENA 2022 Board of Directors Liaison
Ryan Oglesby, PhD, RN, CEN

ENA Staff Liaison
Domenique Johnson, MSN, RN

Developed: 2012.

Approved by the ENA Board of Directors: January 2013.
Revised and Approved by the ENA Board of Directors: March 2018
Revised and Approved by the ENA Board of Directors: TBD