PATIENT HANDOFF/TRANSFER

Description

According to Friesen, et al.,¹ “[t]he transfer of essential information and the responsibility for care of the patient from one health care provider to another is an integral component of communication in health care. This critical transfer point is known as a handoff.” The Joint Commission adds that this patient handoff/transfer includes the acceptance of patient care responsibility achieved through effective communication, as well as an opportunity to ask questions, clarify, and confirm.² This transition occurs countless times, in multiple ways, under various conditions each day across the continuum of patient care. Vital information shared during the handoff/transfer process includes, but is not limited to, patient chief complaint/diagnosis, diagnostic results, care that has been provided, patient response to treatment, and care that has yet to be performed.³ Although The Joint Commission requires accredited organizations to use a standardized approach to handoff communications, approximately 80% of serious medical errors occur due to high miscommunication rates during patient handoffs/transfers.²

ENA Position

It is the position of the Emergency Nurses Association that:

1. The development and use of standardized approaches facilitate safe and effective patient handoffs.
2. Patients and families are involved in handoff communication and information sharing when appropriate.
4. Handoff/transfers occur between caregivers of equal or higher levels of knowledge, skills, and clinical judgment to meet the patient’s continuing care requirements.

Background

The impact of ineffective handoffs/transfers includes such adverse events as delays in diagnosis and treatment, fragmented care, breaches in care, medication errors, conflicting communication, duplication of procedures/tests, lower provider and patient satisfaction, higher costs, longer and more frequent hospital stays, and patient deaths.¹⁴⁵ Recognizing handoffs as a critical patient safety issue, The Joint Commission teamed with a group of U.S. hospitals and health care systems through its Center for Transforming Healthcare to explore the use of new methods to reduce dangerous and potentially deadly breakdowns in patient care.²⁶ SHARE,⁶ SBAR,⁷ and TeamSTEPPS⁸ are a few of the systems and processes identified in the literature for the purpose of standardizing patient handoff/transfers to reduce the risks to patient. Additionally, Griffin⁹ described the benefits of report at the bedside, Braun³ discussed use of the electronic medical
record to standardize information, and Chang et al.\textsuperscript{5} demonstrated that education and use of standardized guidelines and processes reduced errors and improved critical care patient outcomes.\textsuperscript{3,5,9} Additional strategies are necessary to address and improve the process of safely transitioning the patient across continuums.

References


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Position Statement

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