



# Position Statement

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## Patient Transfers and Handoffs

### Description

The transfer or handoff of pertinent information from one healthcare provider to another is a fundamental aspect of communication in healthcare.<sup>1</sup> 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 between the caregivers.<sup>2</sup> This transition occurs countless times, in multiple ways, under various conditions each day across the continuum of patient care, from prehospital to long term care, but it is likely that more handoffs occur in the emergency department than anywhere else.<sup>2</sup> 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.<sup>3</sup> The Joint Commission recognizes that a critical patient safety problem in healthcare is ineffective handoff communication.<sup>4</sup> In fact, 80% of serious medical errors are associated with high miscommunication rates during patient handoffs.<sup>2,4</sup> As a result, the Joint Commission began requiring that accredited organizations use a standardized approach to handoff communications.<sup>2,4</sup>

### ENA Position

It is the position of the Emergency Nurses Association that:

1. Handoff protocols, to meet the patient's continuing care requirements, take into consideration the fact that handoffs occur between caregivers of various levels of knowledge, skills, and clinical judgment.
2. Organizations use standardized approaches, integrating their unique characteristics to facilitate safe and effective patient handoffs.
3. Patients, families, and all levels of caregivers, be involved in handoff communication and information sharing.
4. Emergency nurses and support personnel receive education and training regarding best practices and the importance of patient handoffs.

### Background

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.<sup>1,5,6</sup> 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.<sup>7</sup> Some of the methods used include SHARE,<sup>7</sup> SBAR,<sup>8</sup> TeamSTEPPS,<sup>9</sup> and I-PASS.<sup>10</sup> These systems and processes were



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identified in the literature as standardized patient handoff and transfer methods that reduce risks to patients.<sup>10</sup> Others described the benefits of report at the bedside,<sup>10</sup> discussed the use of electronic medical records to standardize information,<sup>3</sup> and demonstrated that education and the use of standardized guidelines and processes reduced errors and improved critical care patient outcomes.<sup>6</sup> Additional study is necessary to establish practices that will improve the process of safely transitioning the patient through the many levels of providers in the healthcare continuum.<sup>2</sup>

## Resources

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