EMERGENCY NURSES ASSOCIATION

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.[1] 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.[2] 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.[2] 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.[3] The Joint Commission recognizes that a critical patient safety problem in healthcare is ineffective handoff communication.[4] In fact, 80% of serious medical errors are associated with high miscommunication rates during patient handoffs.[2,4] As a result, the Joint Commission began requiring that accredited organizations use a standardized approach to handoff communications.[2,4]

ENA Position

It is the position of the Emergency Nurses Association (ENA) 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 judgement.

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.[1,5,6] 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.[7] Some of the methods used include SHARE,[7] SBAR,[8] TeamSTEPPS,[9] and I-PASS.[10] These systems and processes were identified in the literature as standardized patient handoffs and transfers methods that reduce risks to patients.[10] Others described the benefits of report at the bedside,[10] discussed the use of electronic medical records to standardize information,[3] and demonstrated that education and the use of standardized guidelines and processes reduced errors and improved critical care patient outcomes.[6] 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.[2]

Resources

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Emergency Medicine Committee and Emergency Nurses Association Pediatric Committee. (2016). Handoffs: Transitions of care for children in the emergency department. *Pediatrics*, *138*(5), 1-12. https:doi.org/10.1542/peds.2016-2680

The Joint Commission. (2017). Transitions of care (ToC) portal. Retrieved from https://www.jointcommission.org/toc.aspx

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2017). Handoffs and signouts. Retrieved from https://psnet.ahrq.gov/primers/primer/9/handoffs-and-signouts.

References

1. Friesen, M. A., White, S. V., & Byers, J. F. (2008). Handoffs: Implications for nurses. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK2649/?report=reader
2. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Emergency Medicine Committee and Emergency Nurses Association Pediatric Committee. (2016). Handoffs: Transitions of care for children in the emergency department. *Pediatrics*, *138*(5), 1–12. https://doi.org/10.1542/peds.2016-2680
3. Braun, B. D. (2012). Evaluating and improving the handoff process. *Journal of Emergency Nursing, 38*(2) 151–155.
4. The Joint Commission. (2012, August). Joint Commission Center for Transforming Healthcare releases targeted solutions tool for hand-off communications. *Joint Commission Perspectives, 32*(8). Retrieved from https://www.jointcommission.org/assets/1/6/tst_hoc_persp_08_12.pdf
5. Patterson, E. S., & Wears, R. (2010). Patient handoffs: Standardized and reliable measurement tools remain elusive. *The Joint Commission Journal on Quality and Patient Safety*, *36*(2), 52–61.

6. 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) 140–145. https://doi.org/10.1016/j.jen.2009.07.019
7. Joint Commission Center for Transforming Healthcare. (2010, October 21). Joint Commission Center for Transforming Healthcare tackles miscommunication among caregivers. Retrieved from http://www.pwrnewmedia.com/2010/jointcommission_01021_miscommunication/index.html
8. Hohenhaus, S., Powell, S., & Hohenhaus, J. (2006). Enhancing patient safety during hand- offs: Standardized communication and teamwork using the 'SBAR' method. *American Journal of Nursing, 106*(8), 72A–72C. Retrieved from http://www.idahosimnetwork.org/enhancingHandoffs.pdf
9. Association of Perioperative Registered Nurses. (n.d.). *Patient hand off tool kit: Executive summary.* Retrieved from https://www.aorn.org/-/media/aorn/guidelines/tool-kits/patient-hand-off/update-022016/handoff-over_tool%20kit%20executive%20summary.pdf?la=en
10. 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

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