PATIENT HANlOFF/ TRANSISITONS IN CARE

Purpose:
To define a safe process to convey important information about a patient’s care when transferring care responsibility from one physician to another, one nurse to another, or among other licensed or unlicensed personnel, or when a patient leaves LSUHSC-S for another site of care.

Background: In the course of patient care it is often necessary to transfer responsibility for a patient’s care from one physician or nurse to another. The primary objective of a “handoff” is to provide complete and accurate information about a patient’s clinical status, including current condition and recent and anticipated treatment. The information communicated during a handoff must be complete and accurate to assure safe and effective continuity of care.

Policy:
Handoffs follow a standardized approach and include the opportunity to ask and respond to questions. A handoff is a verbal and/or written communication, which provides information to facilitate continuity of care.

1. Persons Affected
   a. This policy applies to all healthcare personnel who discharge or send a patient to other sites for care.
   b. It also affects staff in other areas of LSUHSC-S (such as diagnostic and treatment area professional staff) who may need to communicate information when a patient changes location of care.

2. Definitions and Additional Information
   a. A “handoff” or “report” occurs each time that an inpatient, emergency room patient, clinic patient, observation patient or any other patient:
      1). Moves to a new unit
      2). is transported to or from a different area of LSUHSC-S for care (e.g. diagnostic/treatment area)
      3). is assigned to a different nurse, temporarily (e.g. lunch break) or longer (e.g. shift change)
      4). is assigned to a different physician temporarily (e.g. night float) or longer (e.g. rotation change)
      5). is discharged to another institution or facility from LSUHSC-S into the care of a physician or nurse or is transferred to LSUHSC-S from another institution or facility

Each of these situations requires a structured handoff with appropriate communication.
b. In some areas of LSUHSC-S, a handoff also occurs among non-licensed personnel, i.e. NA to another staff member in the same position. A consistent approach to handoff communication is encouraged and it is the prerogative and responsibility of the manager of each area to evaluate the best approach to assure effective communication. This may include developing tools for the non-licensed staff handoff, which use the same principles and approach as that mandated by this policy for nurses and physicians.

c. **Additional characteristics** of a high quality handoff:
   1). Handoffs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information.
   2). Handoffs include up-to-date information regarding the patient’s care, treatment and services, condition and any recent or anticipated changes.
   3). Interruptions during handoffs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.
   4). Handoffs require a process for verification of the received information, including repeat-back or read-back, as appropriate.
   5). The receiver of the handoff information has an opportunity to review relevant patient historical data, which may include: previous care, treatment and services.

3. Responsibilities

   a. Department Managers:
      1). Department Managers ensure that the handoff and report form, or verbal-handoff guideline, designed for use on their unit is consistent with the needs of patients in the unit, and is used consistently and correctly.
      2). They also ensure that staffing supports interaction of the sending and receiving nurse with minimal interruptions and with the opportunity to ask questions.
      3). Department Managers evaluate handoffs among non-licensed staff such as NA staff and determine whether structured handoff approaches are appropriate.

   b. Healthcare Personnel
      1). Comply with handoff policy and procedures; resolve discrepancies and concerns timely.
      2). Applies to all licensed and non-licensed healthcare personnel, such as technologist, NA, etc.

   c. Physician Leadership as Designated by Clinical Chair in Each Department:
      1). Establish the process for and maintain the performance of handoff procedures in accordance with the requirements in this policy.
      2). Ensure that house staff provides information needed for timely, accurate, complete and effective handoff in accordance with the requirements in this policy.

   d. Physicians (attending and house staff):
      Comply with handoff policy and procedures; resolve discrepancies and concerns timely.

Procedure:

1. Medical Staff and Residents:
a. Handoff procedures and information transfer forms/guidelines for physicians are developed and implemented by each service according to the needs of that service. The handoff forms or guidelines may be in either paper or electronic format, and must include clinical information agreed upon by physicians in that service as being integral to the provision of safe and effective patient care for that patient population.

b. Each service develops and implements a handoff process that is in keeping with the shift/rotation change practices of its physicians and that facilitates the smooth transfer of information from physician to physician.

c. Each handoff process must include the opportunity for the oncoming physician to ask questions and request information from the reporting physician.

d. Within each service, handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline.

2. Transferring physician:
   Handoff verbal &/or written should include at a minimum (as applicable)

   a. Patient name, location, age/date of birth
   b. Patient diagnosis/problems, impression
   c. Important prior medical history
   d. DNR status and advance directives
   e. Allergies
   f. Medications, fluids, diet
   g. Important current labs, vitals, cultures
   h. Past and planned significant procedures
   i. Specific protocols/resources/treatments in place (DVT/GI prophylaxis, insulin, anticoagulation, restraint use, etc)
   j. Plan for next 24+ hours
   k. Pending tests and studies which need follow up
   l. Important items planned between now and discharge

3. Receiving physician:
   Review handoff form or receive verbal handoff, and resolve any questions with transferring physician.

4. Nurses:

   a. Each nursing unit is responsible for implementing the information transfer processes/forms, guidelines for verbal handoff or supporting procedures that are in keeping with handoff principles. The handoff may be in either verbal, paper or electronic format, and must include clinical information agreed upon by nursing staff on that unit as being essential to the provision of safe and effective patient care for that patient population and that facilitates the smooth transfer of information from nurse to nurse.
b. General Medicine and Surgery Patient Care Units may use a Kardex, report sheet or electronic SBAR (Situation, Background, Assessment, Recommendation) Handoff tools, but are required to document the handoff in the electronic record (See item 5a)

c. Each handoff process must include the opportunity for the oncoming nurse or receiving nurse to ask questions and request information from the reporting nurse.

d. Handoffs will be conducted in a consistent manner, using a standardized handoff form or guideline e.g. SBAR handoff.

e. When moving a patient for transfer, discharge, or transport, the sending and receiving nurses should review written documentation forms as appropriate during downtimes along with the patient’s paper medical record (Lite Chart). If not, the receiving nurse should have contact information and be able to contact the sending nurse so that any questions can be asked and answered.

f. At the conclusion of the handoff conversation, dispose of Kardex and/or report sheet at the appropriate time in a secured container.

5. Nursing Documentation

a. Change of Shift/Change of Assignment/Unit to Unit Transfer (including Clinic and ED), the giver and receiver of handoff must document all components of the handoff including who report was given to, if questions were asked, who report was received from and if the opportunity to ask questions was provided. For the temporary change assignment i.e. meal break or lab run, medical record documentation will not be necessary as the charge nurse will be responsible for communication concerning the patients in typical unit activities. However, the assigned nurse is responsible for handoff to the charge nurse.

b. Provider Notification, when it becomes necessary to notify the physician provider of patient status change, critical lab results, and any other situations regarding the patient; details of the notification shall include the provider name/role, date, time, situation, how it was communicated, read back and the physician’s response.

c. Transfer to a higher or lower level of care, the nurse shall document in a note the telephone handoff to the receiving facilities nurse, identifying that nurse.

d. Transport for diagnostic testing, the stable patient will have a “Ticket to Ride” and the Lite Chart. The Unstable patient will be accompanied by the nurse and the Lite Chart.

6. Discharge Instructions are incorporated into the After Visit Summary and are printed off by the RN/LPN and given to all patients discharged home. Additional discharge instructions may be communicated via unit/procedure specific documents.

7. Discharge to non acute care

Physician documentation, the discharge summary will be sent to non acute care facilities (e.g. nursing homes, prisons). Included in this discharge summary/information will be the discharge
mode and vital signs. The nurse will make a telephone report to the receiving facility as appropriate.

8. Discharge to acute care, Inter-Hospital Transfer

Physician Form - The **Memorandum of Inter-Hospital Transfer** (both S/N 1303/1330) will be completed by the MD prior to transferring a patient to another acute care facility and will be accompanied by the physician’s discharge summary and all salient portions of the patient medical record. The nurse will make a telephone report to the receiving nurse.

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Administrator

3/20/13

Date

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