Improving Hand-Off Communications
New Solutions for Nurses

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LAPSES in complete, accurate communication between caregivers when responsibility for patients is transferred or “handed off” are a major issue affecting the quality and safety of patient care. Although the primary objective of a hand-off during a transition of care is to provide accurate information about a patient’s care, current condition, and any recent or anticipated changes, unfortunately each hand-off can present unique opportunities for error. One study estimates that 80% of serious medical errors involve miscommunication between caregivers during such transitions in care.1 Communication breakdowns during transitions of care were a leading cause of sentinel events reported to The Joint Commission between 1995 and 2006.2

Health care organizations have long struggled with the process of passing necessary and critical information about a patient from one caregiver to the next or from one team of caregivers to another. A hand-off involves “senders,” the caregivers transmitting patient information and releasing the care of the patient to other providers, and “receivers,” the caregivers who accept the patient information and care of the patient. One recent project found that, on average, more than 37% of the time hand-offs are defective and do not allow the receiver to safely care for the patient.3 In addition, 21% of the time senders are dissatisfied with the quality of the hand off.3

PROFESSIONAL NURSES AND HAND-OFFS

Change-of-shift reporting among nurses is one of the more common hand-offs in health care organizations. Shift changes require nurses to exchange vital information that will guide the patient’s care during the next shift. However, effective communication between nurses is often hampered. Reasons for gaps in information handed off from one nurse to another include the following4:

• New admissions just prior to shift change
• Time available to conduct transitions of care
• Lack of sender’s knowledge about an individual patient’s condition
• Focus on tasks performed rather than patient outcomes
• Use of agency nurses (or those unfamiliar with the patient) and the large number of nurses involved in each patient’s care add to difficulties in exchanging complete and accurate information.

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When patients move from the emergency department to an inpatient unit, nurses face a variety of barriers to effectively executing hand-offs. For example, the emergency department nurse and the receiving patient care unit nurse may not agree when the transfer of responsibility for the patient begins. Some nurses think it begins with the “report” call to the unit to inform the receiving nurse about the patient who is being transferred. Others believe that the transition of care is not complete until all the essential information about the patient has been communicated directly to the receiving nurse and the patient has been physically transferred. Emergency department nurses and unit nurses also may not have a clear and complete understanding of one another’s roles, which can make it difficult for the emergency department nurse to know what information needs to be shared for a successful transition of care.

Another common hand-off issue for nurses involves communication with physicians. A 2009 survey by the American College of Physician Executives found that nearly 85% of nurses and physicians reported a lack of respect in communication. A reluctance to communicate concerns about a patient prior, during, or after a transition of care can lead to inadequate patient safety management.

SEARCH FOR ROOT CAUSES AND SOLUTIONS

Although Joint Commission-accredited organizations are required to use a standardized approach to hand-off communications, defective hand-offs are known to cause problems beyond adverse events, such as delays in treatment, inappropriate treatment, and increased length of stay. Recognizing hand-off communications as a critical patient safety issue, 10 leading hospitals and health systems in the United States set out to address the issues in transitions of care by using Robust Process Improvement™ (RPI), a fact-based, systematic, and data driven problem-solving methodology.

The hospitals, working closely with the Joint Commission Center for Transforming Healthcare, sought to discover specific risk points and contributing factors to difficulties in hand-off communications. Solutions that targeted these specific risk points and contributing problem factors were then developed and implemented to improve the effectiveness of communication during transitions of care. Validated root causes for handoff communications failures included a culture that does not promote successful hand-offs (eg, lack of teamwork and respect); differing expectations between sender and receiver; ineffective communication methods (eg, verbal, recorded, bedside, written); timing of the physical transfer of the patient and hand-off and not in sync; an inadequate amount of time provided for a successful hand-off; interruptions that occur during hand-off; lack of standardized procedures in conducting a successful hand-off (eg, situation background assessment recommendation [SBAR]); inadequate staffing at certain times of the day or week to accommodate successful hand-off; and the patient not included during hand-off.

Other validated root causes included senders who provide inaccurate or incomplete information (eg, medication list, Do Not Resuscitate, concerns/issues, contact information); who have little knowledge of the patient and are handing off this patient to the receiver; who are unable to provide up-to-date information (eg, lab tests, radiology reports) because they are not available at the time of hand-off; and who are unable to contact in a timely manner the receiver who will be taking care of the patient. Other issues that were identified included the inability of the sender to follow up with the receiver if additional information needs to be shared, sender asked to repeat information that has already been shared, receiver has competing priorities and is unable to focus on the transferred patient, receiver is unaware of the patient transfer, inability for the receiver to follow up with the sender if additional information is needed, lack of responsiveness by the receiver, and receiver has little knowledge of the patient being transferred post hand-off.
The pilot project has now moved beyond the original 10 participating hospitals and health systems and is being tested in greater numbers of demographically diverse hospitals at the time of this publication. The original 10 participating organizations that fully implemented the Center’s solutions achieved an average 52% reduction in defective hand-offs by using new strategies described using the acronym SHARE. Each of the strategies makes clear that changes in long-standing patterns of ineffective communication between caregivers will not occur without the support of organization leadership.

Specifically, SHARE refers to the following:

- **Standardize critical content**, which includes providing details of the patient’s history to the receiver, emphasizing key information about the patient when speaking with the receiver, and synthesizing patient information from separate sources before passing it on to the receiver.

- **Hardwire within your system**, which includes developing standardized forms, tools and methods (such as checklists), identifying new and existing technologies to assist in making the hand-off successful, and stating expectations about how to conduct a successful hand-off.

- **Allow opportunity to ask questions**, which includes using critical thinking skills when discussing a patient’s situation as well as sharing and receiving information as an interdisciplinary team. Receivers should expect to receive all key information about the patient from the sender, receivers should scrutinize and question the data, and receivers and senders should exchange contact information in the event there are any additional questions.

- **Reinforce quality and measurement**, which includes demonstrating leadership commitment to successful hand-offs such as holding staff accountable, monitoring compliance with use of standardized forms, and using data to determine a systematic approach for improvement.

- **Educate and coach**, which includes organizations teaching staff what constitutes a successful hand-off, standardizing training on how to conduct a hand-off, providing real-time performance feedback to staff, and making successful hand-offs an organizational priority.

**How nurses can “SHARE”**

The continual contact that nurses have with patients provides nurses with multiple opportunities to implement actions to improve hand-off communications throughout their organizations. Nurses are key leaders and stakeholders in all organizational efforts to improve care; they must play a role both through being individually accountable for effective hand-offs and helping create a culture that engages in safe transitions of care. As change agents, nurse leaders can advocate at the policy level for implementing creative SHARE solutions for hand-off communications. Nurses can continue to identify barriers to safe and effective hand-offs and use targeted strategies to solve these problems in delivering safe, quality care.

Nurses can assume a leadership role by working with other disciplines to review current processes and doing an initial inventory of existing transition-of-care communication processes. After determining what transition-of-care processes exist currently, processes can be analyzed by comparing the information that needs to be provided during each transition of care with the information that is actually being provided. If the appropriate information is already being shared and both senders and receivers are satisfied with the quality and quantity of information provided, the organization may already have an effective standardized method for communication during transitions of care and processes do not need to be revised.

In addition, nurses can participate in organization-wide efforts through the use of the Targeted Solutions Tool™ (TST), which exemplifies the work of the Joint Commission Center for Transforming Healthcare. This tool provides a step-by-step process to
measure performance, identify barriers to excellent performance, and implement proven solutions. The Targeted Solutions Tool offers the same improvement processes used by the Center’s participating organizations; organizations do not need statistical data analysis capabilities or any specialized performance improvement expertise to use the TST. The solutions developed for the Center’s first project on improving hand hygiene are available now for Joint Commission accredited and certified organizations through the secure Extranet site. The hand-off solutions will be added to the TST in the second half of 2011. Data entered into the TST are confidential and the organization’s property; they will not be shared with The Joint Commission. Use of the tool is voluntary for those organizations who want to improve patient safety and quality in these high risk or problem prone areas.

CONCLUSION

Effective communication among caregivers is critical to seamless hand-offs that result in safe, high-quality care through analyzing key processes from the perspectives of both the sender and the receiver. By employing solutions developed through use of RPI tools, nurses and other health care professionals can examine why processes fail to achieve desired results and implement targeted, long-lasting patient safety solutions.

REFERENCES