Hand-off Resources

Bates DW, Gawande AA. Improving safety with information technology. *N Engl J Med* 2003;348(25):2526-2534.

Coleman EA, Berenson RA. Lost in transition: challenges and opportunities for improving the quality of transitional care. *Ann Intern Med* 2004;141(7):533-536.

Cook RI. A brief look at gaps in the continuity of care and how practitioners compensate for them. 2004. http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_37118_0_0_18 /Richard%20Cook%201.pdf. Accessed April 20, 2007.

Cook RI, Render M, Woods DD. Gaps in the continuity of care and progress on patient safety. *BMJ* 2000;320(7237):791-794. http://bmj.bmjjournals.com/cgi/content/full/320/7237/791. Accessed April 20, 2007.

Gandhi TK. Fumbled hand-offs: one dropped ball after another. *Ann Intern Med* 2005;142(5):352-358.

Van Eaton EG, Horvath KD, Lober BW, Rossini AJ, Pellegrini CA. A randomized, controlled trial evaluating the impact of a computerized rounding and sign-out system on continuity of care and resident work hours. *J Am Coll Surg* 2005;200(4):538-545.

Vidyarthi A. Fumbled Handoff. Agency for Healthcare Research and Quality. March 2004. http://www.webmm.ahrq.gov/case.aspx?caseID=55. Accessed April 20, 2007.

Web sites

AHRQ Resources

- **Agency for Healthcare Research and Quality (AHRQ)** web site. Search on the term "hand-off" for references and links. http://www.ahrq.gov/qual.

- **Advances in Patient Safety: From Research to Implementation.** A spectacular compendium of articles with links to the PDF or Word files from these pages. http://www.ahrq.gov/qual/advances/.

- **Analysis and Artifacts: Process mapping and mistake-proofing.** Process management techniques to move the patient across a system of care. AHRQ Patient Safety Conference June 6-10, 2005, Washington, DC. John Grout. (Graphic and system representation of care, hand-offs, and errors during transitions of care.) http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_37152_0_0_18/Grout.ppt#318,19,Applied behavior analysis.

- **Barriers Associated with Medication Information Hand-offs.** K. Bruce Bayley, Lucy A. Savitz, Glenn Rodriguez, William Gillanders, Steve Stoner. http://www.ahrq.gov/downloads/pub/advances/vol3/Bayley.pdf.

- **Changing the Healthcare Culture: Process and change.** Gary R. Yates. http://www.ahrq.gov/qual/qsummit/qsummit4.htm#sentara.

- **Five Presentations Available on Managing Clinical Hand-offs Across Care Settings.**
  - Bruce Ferguson http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_40420_0_0_18/Ferguson.ppt.
  - Carol Ireson http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_40422_0_0_18/Ireson.ppt.
  - Wendy Angelo, Daniel Venecek http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_40423_0_0_18/Venecek.ppt.
  - Gail Keenan, Elizabeth Yakel http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_39921_0_0_18/Keenan.ppt. (Excellent slide and IT solution for nursing hand-offs.)
  - Jerry Gurwitz http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_40421_0_0_18/Gurwitz.ppt.

- **National Center for Health Information Technology, Annual Conference 2005.** http://healthit.ahrq.gov/portal/server.pt?open=514&objID=5554&mode=2&holderDisplayURL=http://prodportallb.ahrq.gov:7087/publishedcontent/publish/communities/k_o/knowledge_library/features_archive/features/2005_annual_conference.html.

- **Older Patient Care and Patient Safety Across Settings and Populations.** Judith Sangl. Adverse events during these transitions. Strategies for improvement. Best practices and development of vetted transfer forms**.** http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_3141_37131_0_0_18/E.%20ColemanJ.Sangl.ppt#1.

Facts about the 2007 National Patient Safety Goals. Joint Commission Center for Patient Safety. http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_npsg_facts.htm.

NPSG 2E: Patient Safety Practices Related to Patient Safety Goal. Joint Commission International Center on Patient Safety. http://www.jcipatientsafety.org/22844/.

Chapter 10: Hand-offs and Fumbles. Wachter R, Shojania K. In: *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes.* Rugged Land, LLC; 2004.
Tools for Practitioners, Researchers and Policy Makers. University of Colorado at Denver Health Sciences Center. Health Care Policy and Research. The Care Transitions Program. http://www.caretransitions.org/practitioner_tools.htm.

Patient Hand-off System Improvement. Bae S, Guerrero M, Kim L, O'Quinn P, Tabatabaian L. In: Bass EJ, ed. *Proceedings of the 2005 Systems and Information Engineering Design Symposium*. http://www.sys.virginia.edu/sieds05/proceedings/B204.pdf.