“Hand-off” Toolkit to Improve Transitions in Care Within the Perioperative Environment

Executive Summary

For more than 12 years, The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations, has evaluated reportable medical errors, stratifying the root causes from which recommendations for improvement have been made. From 1995 to 2004, with more than 3,000 sentinel events analyzed, The Joint Commission identified communication as the top contributing factor of medical error (65% of sentinel events reported were caused by communication problems). In 2005, that percentage increased to 70% with an analysis identifying at “least half of the communication breakdowns occurring during hand offs.”1 This information coupled with studies revealing that a majority of the avoidable adverse events are due to the lack of effective communication (ie, lost information, misinterpretation, and misdirected or missed actions)2 has spurred a national movement to improve communication within and between healthcare teams to ensure patient care information is communicated consistently during all patient “hand offs” and patient care transitions.

The Association of periOperative Registered Nurses (AORN) formed a relationship with the Department of Defense Patient Safety Program (DoD PSP) to develop guidance for perioperative nurses in meeting the challenge put forth by both the Institute of Medicine’s request to prevent medical errors through the optimization of team performance and patient outcomes across healthcare, as well as The Joint Commission requirement to improve patient “hand offs.”3,4 AORN has modeled a hand-off toolkit for use within the perioperative environment from the resource developed by the DoD PSP titled “Healthcare Communications Toolkit to Improve Transitions in Care.” This toolkit is derived from the evidence-based team training curriculum used by the DoD called TeamSTEPPS™ (Team Strategies and Tools to Enhance Performance and Patient Safety). This effort to disseminate the TeamSTEPPS initiative widely is in concert with the vision of David Tornberg, MD, Assistant Secretary of Defense for Health Affairs, to “…join
forces to bring a much-needed product into the public domain … we want to see TeamSTEPPS used in both military and community health settings.”

The DoD Patient Safety Program extended permission to AORN to customize the existing materials with a focus specifically on perioperative settings. Perioperative settings are technologically complex patient care environments with multidisciplinary teams making timely coordinated interventions in acute situations to minimize adverse events, near misses, or inefficiency throughout the continuum of surgical care. “Medical errors in surgical patients can lead to catastrophic patient outcomes.”

The customized TeamSTEPPS program is an opportunity for the surgical team to diminish the risk of error and improve patient outcomes by creating a structure to support standardized “hand-offs” and improve communications during care transitions within the perioperative environment. Taking the original toolkit designed by the DoD Patient Safety Program, with the “perioperative lens” in place, AORN modified the language and situational examples to fit the surgical and procedural settings. Specifically, guidance is provided with regard to information related to The Joint Commission requirements. Numerous tools, mnemonics, and strategies are used as templates, with the objective being improved “hand offs” and patient care transitions. Human factors research, scientific evidence, and identifiable best practices are also outlined. AORN is not advocating one tool or strategy over another; however, AORN stresses that The Joint Commission requirements should be adhered to as a minimal standard from which healthcare organizations can expound to enhance communications and patient care “hand-off” transitions.

The Joint Commission National Patient Safety Goal on Hand-off Communications

In an effort to simplify the terminology in this tool kit, transitions in patient care will be referred to as “hand offs.” The primary objective of a hand off is to provide accurate information about a patient’s, client’s, or resident’s general care plan, treatment, services, current condition, and any recent or anticipated changes. Not only is dissemination
important but accuracy of the information is vital to the success of the hand off process. To accomplish the above, The Joint Commission’s National Patient Safety Goal 2E outlines minimal requirements from which organizations are to establish a hand off process. To meet the intent of the goal, organizations must “implement a standardized approach to ‘hand off” communications, including an opportunity to ask and respond to questions.” This requirement is applicable to the following:

- Ambulatory Care
- Assisted Living
- Behavioral Health Care
- Critical Access Hospital
- Disease Specific Care
- Hospital
- Laboratory
- Long Term Care
- Office-Based Surgery
- Home Care

Multiple patient hand offs occur in healthcare settings during the transfer of patient care responsibility. In the perioperative environment, these patient hand offs occur at different points as the patient navigates through the perioperative continuum of care to include the surgeon’s office, OR scheduling office, admission department at the facility providing the care, preoperative assessment, OR, PACU, nursing unit, discharge department, and finally back to the surgeon’s office for the postoperative assessment. Specific examples that demonstrate the points in the process where the transfer of responsibility for the surgical patient occurs include, but are not limited to, the following:

### 2007 National Patient Safety Goals

**Requirement 2E**

Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.

**Rationale for Requirement 2E**

The primary objective of a “hand off” is to provide accurate information about a patient’s care, treatment, and services, current condition and any recent or anticipated changes. The information communicated during a hand off must be accurate in order to meet patient safety goals.

In health care there are numerous types of patient hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a patient, physicians transferring on-call responsibility, temporary responsibility for staff leaving the unit for a short time, anesthesiologist report to post-anesthesia recovery room nurse, nursing and physician hand off from the emergency department to inpatient units, different hospitals, nursing homes and home health care, critical laboratory and radiology results sent to physician offices.

Hand-off Communications

- Shift change or break relief
- Physician to surgeon/nurse to nurse/surgical technician to surgical technician transfer of patient responsibility
- Surgical team (surgeon, nurse, surgical technologist) transfer of on-call responsibility
- Report to postanesthesia recovery room nurse by a member of the surgical team
- Nursing and surgeon hand off from the perioperative area to inpatient units
- Critical laboratory and radiology results disseminated to the surgical team
- Members of the surgical team to another level of care
- From one hospital to another

**Implementation Expectations (National Patient Safety Goal 2E):**

Preparing for the implementation deadline of January 1, 2006, The Joint Commission published expectations for the 2E requirement based on human factors and health-services research, best practices in high-reliability organizations, and expert opinion in areas of teamwork and healthcare communication. Below are The Joint Commission “attributes” of effective hand-off communications:\(^3,^8:\)

- Hand offs are interactive communications allowing the opportunity for questioning between the giver and receiver of patient/client/resident information.
- Hand offs include up-to-date information regarding the patient’s/client’s/resident’s care, treatment and services, condition, and any recent or anticipated changes.
- Interruptions are limited during hand offs to minimize the possibility that information would fail to be conveyed or would be forgotten.
- Hand offs require a process for verification of the received information, including repeat-back or read-back, as appropriate.
The receiver of the hand off information has an opportunity to review relevant patient/client/resident historical data, which may include previous care, treatment, and services.

References:


The US Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) has made patient safety a national priority, with the goal
being to disseminate innovative ideas and tools to the public to improve health care. In collaboration with the DoD Patient Safety Program, AHRQ has placed the TeamSTEPPS toolkit on their web site: http://www.ahrq.gov/qual/teamstepps/. This program can also be viewed on the Uniformed Services University of the Health Sciences web site: http://www.usuhs.mil/cerps/teamstepps.html. Single copies of the TeamSTEPPS products can be obtained free of charge from AHRQ Publications Clearinghouse by calling 800-358-9295, sending an e-mail to AHRQPubs@ahrq.hhs.gov, or using the ordering form on the AHRQ web site at www.ahrq.gov/qual/teamstepps.