“Hand-off” Tool Kit 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 to 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 caused by lack of effective communication (ie, lost information, misinterpretation, misdirected or missed actions)² spurred a national movement to improve communication within and between health care teams to ensure patient care information is communicated consistently during all patient hand offs (also called hand overs) 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 call to prevent medical errors through the optimization of team performance and patient outcomes across health care and The Joint Commission’s requirement to improve patient hand offs.³,⁴ AORN has modeled a hand-off tool kit for use within the perioperative environment after the resource developed by the DoD PSP titled “Healthcare Communications Toolkit to Improve Transitions in Care.” The AORN tool kit is derived from TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety)⁵,⁶, the evidence-based team training curriculum used by the DoD.

This effort to widely disseminate the TeamSTEPPS initiative 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.”³

The DoD PSP extended permission to AORN to customize the existing materials with a focus specifically on perioperative settings. Perioperative settings are technologically complex patient care environments in which multidisciplinary teams make timely coordinated interventions in acute situations to minimize adverse events, near misses, or inefficiency throughout the continuum of surgical care.⁴ “Medical errors in surgical patients can lead to catastrophic patient outcomes.”⁴(p407)

Using the customized TeamSTEPPS program provides an opportunity for the surgical team to diminish the risk for 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 tool kit designed by the DoD PSP, with the “perioperative lens” in place, AORN modified the language and situational examples to fit the surgical and procedural settings. 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 emphasizes that The Joint Commission’s patient safety and quality “SHARE” principles should be adhered to as a minimal standard on which health care organizations can expand upon to enhance communication and patient hand-over transitions.¹

The Joint Commission 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 off.” 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 Center for Transforming Healthcare offers organizations tools with effective solutions for improving transitions of care and hand-off communications, with the goal of transforming health care into a highly reliable industry. The Center’s Hand-off Communications Targeted Solutions Tool® (TST) assists health care organizations “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, to prevent miscommunication-related errors.”¹ The AORN tool provides a means to examine your current hand-off communication process and a measurement system that can produce the data you need to garner support for improving your current processes.

The solutions offered by the Joint Commission as part of the TST use the acronym “SHARE”:
- Standardize Critical Content
- Hardwire Within Your System
- Allow Opportunity to Ask Questions
- Reinforce Quality and Measurement
- Educate and Coach

These principles are applicable to the following care settings:
- 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 health care settings during the transfer of patient care responsibility. In the perioperative environment, these patient hand offs occur at different points in the continuum of care, including the surgeon’s office, OR scheduling office, admission department at the facility where care is provided, preoperative assessment, OR, postanesthesia care unit, 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:

- 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 care unit 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

### Implementing The Joint Commission’s Expectations

The TST tool measures the organization’s hand-over effectiveness and provides proven solutions to improve hand-off performance. The lack of effective communication during the hand off between health care providers can lead to serious medical errors. More recent findings by The Joint Commission are consistent with previous reports that list “breakdown in communication” as a leading cause of sentinel events. The consequences can be inappropriate or delayed treatment, omission of care, readmissions, and increased costs.

Below are The Joint Commission’s “attributes” of effective hand-off communications

- 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.

- Establish a space or setting that limits interruptions during hand offs to minimize the possibility that information would fail to be conveyed or would be forgotten.

- Hand offs require a standardized process, method, and use of tools.

- Integrate existing and new technologies into the hand-off process (eg, electronic health record, mobile devices).
• Verification of received information, including repeat-back or read-back, is 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:


