

A nurse's guide for successful care transition and handoff communication

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A care transition story you may recognize

In 2008, The National Center for Biotechnology Information published *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, which contained an example of a care transition handoff scenario that caught traction with the industry and has been cited several times over the years:

“Nurse Brown on unit A is receiving report from Nurse Green, who is transferring the patient from unit B to unit A. The patient medication administration record (MAR) does not indicate the patient has received any pain medication in the past shift. When Nurse Brown asks about this, Nurse Green realizes she gave morphine sulfate but did not document it on the MAR. Due to Nurse Brown’s question, Nurse Green realizes the omission and communicates the information and documents it in the medical record, preventing an accidental overdose of a medication.”

If you’ve heard it before, or if it resonates with your on-the-job experience, it’s because the need for accurate and comprehensive communication during the handoff is still — even with the advent of EHR processes and automated medication administration — the foundation of successful care transition.

In its simplest form, “care transition” is defined as a hospital discharge or movement from one hospital care setting to another. The risk that readmissions pose to patient safety requires that transitional care processes are constantly under evaluation and scrutiny. And nurses, who are the crux of transition communication, have an increased opportunity to improve good outcomes and reduce adverse events.

Nurses are the key communicators and collaborators in the coordination of patient care, and they are the care team members best equipped to coordinate a successful transition. The bedside nurse, for example, may already have a good idea of the patient’s future needs as he or she travels through the care continuum. And when those needs are communicated effectively, the nurse is given the opportunity to extend to the patient high-value care beyond organizational boundaries.

Nurses create transitional care plans by compiling all the pertinent patient information and creating instructions to be followed. Then they share the plan in detail with all members of the new care team so that the handoff is seamless for both the patient and the new unit or facility.

The most important factor in transition of care is communication during the handoff process.

What to communicate and when

Situations that require handoff communication

- Shift changes
- Meal breaks
- Transfers within the hospital
- Transfers to new facilities: sub- and post-acute
- Discharge to family care

The goal of the handoff is to safely transfer the patient from one care setting to another (or to discharge the patient from the hospital completely) by exchanging the necessary information with, and by effectively transferring the responsibility of care to, either a new care team or the patient's family.

It's a lot to put on any nurse's plate, but by standardizing and implementing an effective and comprehensive transition communication process, you can elevate patient safety, avoid adverse events that lead to costly readmissions, and decrease patient anxiety during the transfer process. The transfer process doesn't apply only to moving a patient from an acute setting to the home or a post-acute environment. There are many different handoff scenarios within the same organization, unit and floor that need your close attention.

It's also extremely important for the purposes of continuity of care that the communication between the nurse and the new team of clinicians, or the family, prepares the new caregivers in such a way that they're able to anticipate the patient's needs and make timely decisions.

At a high level, to adequately prepare the new care team, the handoff communication should include the following:

- Patient care instructions
- Treatment descriptions
- A medication history
- A description of the services the patient has received
- Notes on any recent or anticipated changes in the patient's condition

More specifically, and especially in the case of transfers to a new care team or facility, an effective care transition communication plan will include details like the patient's name and age, the reason for admission, pertinent co-morbidities, the patient's code status and any relevant precautions, any elopement risk, all lab results (and notification regarding

whether any are pending or abnormal), relevant diagnostic studies, a fall risk assessment and any other assessment findings that are appropriate to the patient's current health.

Information to include in handoff communication

- Patient care instructions
- Treatment description
- Medication history
- Services received
- Any recent or anticipated changes
- Patient's name and age
- Reason for admission and pertinent co-morbidities
- Code status
- Current isolation or precautions
- Elopement risk
- Lab results, including pending and/or abnormal findings
- Relevant diagnostic studies
- Any assessment findings that are appropriate to the patient's current health
- Fall risk assessment
- Your personal assessment and recommendations

Check the last page of this report for a printable version of this important checklist.

Many times, nurses on the receiving team end up caring for patients for whom they lack pertinent health data. For example, EKG results are often left out of the transition communication between hospitals and subacute rehabilitation facilities. In that case, if a patient has an episode of chest pain, the receiving team could conduct an EKG on its own, but without prior results for comparison, the team can't definitively rule out something dangerous, such as angina. So the team will err on the side of patient safety and send the patient back to the hospital, resulting in a readmission.

However, if an EKG result is included in the transition communication, the receiving team members can conduct an EKG, compare the results with the EKG performed at the hospital, and determine whether there is an emergent need for a readmission or the issue is something they can safely handle in their own setting.

Pay extra-close attention to medication communications

While including all pertinent test results in the handoff communication is extremely important, there's another area that needs special attention because it causes more admissions than any other factor: medication.

It's estimated that 30% of hospitalized patients have at least one discrepancy on discharge medication reconciliation. And given the popularity of the Nurse Brown and Nurse Green example of transition communication success, this is no doubt an area that poses a great risk for error as well as a great opportunity to effect a positive outcome.¹ In fact, over 66% of emergency readmissions for patients over 65 years old are due to adverse medication events.²

30% of hospitalized patients have at least one discrepancy on discharge medication reconciliation.

– The National Center for Biotechnology Information, 2016

66% of emergency readmissions for patients over 65 years old are due to adverse medication events.

– Becker's Hospital Review, 2015

Breaches in handoff, such as failure to include specific details of the patient's medication history and future dosage needs, can have dire consequences.

A real, on-the-job example of a defective handoff from the webinar *Effective healthcare handoffs to ensure a smooth transition of care*

A 90-year-old patient with a history of severe osteoporosis was convalescing in a subacute facility and needed to have a nurse with her at all times. When the rehab tech stopped by the patient's room to take her to therapy, the nurse told the tech that she was leaving for lunch and would return in 30 minutes.

When the patient and rehab tech arrived at the therapist's office, they found out the appointment had been canceled, and the patient had to be taken back to her room—well before the nurse would be returning from her lunch break. The patient asked the tech whether she could wait outside and, not knowing about her condition, the tech agreed and left her unattended on the patio.

The tech did attempt to communicate handoff details to the nurse's aide and unit secretary by telling both that the patient was waiting for her nurse on the patio. The unit secretary and nurse's aide — also not knowing about the patient's need for constant supervision — thought nothing was out of the ordinary about the tech's report.

A while later, a nurse manager looked out of her office window and saw an empty wheelchair on the patio ... and then the patient alone on the ground.

At first, it seemed the only injury the patient had sustained during the fall was a small skin tear. Within a few hours, however, the nurse reported that her patient was decompensating and had to be readmitted to the hospital.

It's clear to see that a lack of communication — between the nurse and the tech, as well as between the tech and the broader care team — was the root cause of this readmission. The patient's skin tear and more complicated injuries could have been prevented with a comprehensive handoff communication strategy, even though the transfer was for a seemingly innocuous scheduled therapy appointment and short meal break.

Tools for effective handoffs

Tools for effective handoffs

- EHRs
- MARs
- HMPs
- Staff reports
- SBAR communication method
- Clinical communication technology

We've explained how and why effective handoff communication reduces the risk of readmission and improves patient safety, and although there are many steps and players in the transition of care, communication is the most crucial and significant risk point.

Effective communication, at any point in the transition, directly affects the outcome for the patient. It is vital for nurses, who bear the brunt of handoff communication responsibility, to know what resources are available to them in order to prepare the most comprehensive and effective handoff communication possible.

- **Resource #1: Medical records.** Whether they are written or electronic, medical records are the first place nurses should go to begin creating the handoff communication. Be sure to utilize all medical records available, including the MAR, the HMP and full staff reports.
- **Resource #2: The SBAR method.** This military communication tactic was adopted by the healthcare industry in 2002, and for good reason. It eliminates communication problems that arise from differences in

communication styles. It standardizes communication to include:

- **S:** A concise statement of the patient's issues and current **SITUATION**
- **B:** A comprehensive explanation of the patient's **BACKGROUND**, including history, diagnosis, medications, dates and times of dosages, prescribing physicians, etc.
- **A:** An **ASSESSMENT** based on your analysis of the patient's condition
- **R:** Your **RECOMMENDATION** for ongoing successful care
- **Resource #3: Communication tools.** Aside from written reports and face-to-face conversations, nurses can utilize automated and secure clinical communications technology to build effective and easy-to-understand handoff reports that sufficiently prepare the receiving care team to deliver high-value continuity of care.

A foundation for handoff communication success

Time is the most important resource nurses can have at their disposal to ensure their transition communication plans are comprehensive and allow for safe, streamlined continuity of care. Taking the time to communicate your own understanding of the patient's condition and needs—backed up with physician notes, test results and more—is the most certain way you can positively affect the patient's outcome and reduce the risk of adverse events and readmissions.³

Sources

1. *The alarming reality of medication error: A patient case and review of Pennsylvania and national data*, The National Center for Biotechnology Information, 2016.
2. *Reducing unnecessary hospital readmissions: Time to think inside the box*, Becker's Hospital Review, 2015.
3. *Effective healthcare handoffs to ensure a smooth transition of care*, PerfectServe, 2017.

Handoff checklist

Be sure to include the following information in your verbal, written or face-to-face care transition communications:

- Patient care instructions
- Treatment description
- Medication history
- Services received
- Any recent or anticipated changes
- Patient's name and age
- Reason for admission and pertinent co-morbidities
- Code status
- Current isolation or precautions
- Elopement risk
- Lab results, including pending and/or abnormal findings
- Relevant diagnostic studies
- Any assessment findings that are appropriate to the patient's current health
- Fall risk assessment
- Your personal assessment and recommendations