

# Handoff of Care

## Frequently Asked Questions

### What is “handoff of care” communication ?

“Handoff of care” communication is a real-time, interactive process of passing patient specific information from one caregiver or team to another for the purpose of ensuring the continuity and safety of the patient’s care.

### What is the requirement for handoff of care ?

Every hospital must implement a standardized approach to “handoff” communications. This includes an institutional definition of when handoff must occur, what elements must be communicated, that handoff must be “verbal” and include an opportunity to ask and respond to questions, and that “like” handoffs are performed in a consistent way.

### What are “like” handoffs ? Is every handoff the same ? Are we being told how to do handoff ?

The institution is not being proscriptive about how handoff is done. Units or residency programs may decide how they will do handoff. Handoff may be face-to-face, phoned, taped, or may incorporate information from a computerized data source as long as it occurs at specific points of care and includes the five standard elements. For instance, some nursing units do face-to-face change of shift report; others tape record the report. Some residency programs use computer signout; others do only a face-to-face handoff. Either approach is fine as long as it remains consistent within that unit or program and includes the five elements.

### Why is handoff of care important ?

Handoff of care is a National Patient Safety Goal developed by the Joint Commission (JCAHO). All JCAHO-accredited hospitals are required to implement these goals. The University of Virginia Health System is committed to implementing the patient safety goals because it is the right thing to do for our patients.

Medical errors are reported to JCAHO from across the nation. Based on those reports, patient safety goals and recommended strategies to meet them are developed using evidence and expert consensus. The national experience mirrors our local experience and confirms that medical errors occur most frequently at times when health care providers communicate clinical information as providers change or as the patient moves across the continuum of care.

Think about all the times during the day when you communicate clinical information to other caregivers . . . transferring a patient from ICU to acute care, sending a patient for a diagnostic or surgical procedure, giving change of shift or signout report. One recent study shows a 40% increase in resident handoffs since implementation of the “80 hour” rule, with each resident participating in as many as 300 patient handoffs per month. Each transition is a vulnerable point when incorrect information could be conveyed or crucial information omitted.

### When must handoff occur ?

Handoff of care occurs when responsibility for patient care changes due to a change in patient location or change in provider. These are the four types of handoff:

1. Change in level of care
  - inpatient admission *from* the ED, clinic, or procedure area
  - transfer *from* ICU to acute care or *from* acute care to ICU
  - transfer *from* a clinic to the ED
2. Temporary transfer of care
  - *from* inpatient, clinic, or ED to OR, procedure area, diagnostic area
3. Discharge
  - communication to next care provider (if known) at inpatient discharge (via phone, letter, or discharge summary)
  - communication to Home Health provider
  - communication to transfer facility (skilled nursing facility, another hospital)
4. Change in provider or change in service
  - RN / RT change of shift
  - resident signout
  - rotation change (housestaff and faculty)

### What kind of information should be included in handoff . . . or not ?

Handoff should give the accepting clinician a *snapshot* of pertinent information that will enable immediate provision of seamless care. Handoff is *not* a comprehensive communication of every detail of the patient’s history or clinical course. Avoid passing on all possible information in an effort to be comprehensive. Too much data may mask or bury the important nuggets that the next provider needs. Don’t list every medication the patient is on. Talk about new medications, those that require monitoring or adjustment, and suggestions for medications that should be ordered if certain clinical events occur. Don’t pass on every lab test that is ordered or every lab result, especially historical data, orders, or clinical results that are easily accessible using available electronic resources (CareCast or MIS). Communicate critical test results, planned diagnostic procedures, and the plan of care associated with those results.

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### Are there standard elements that are required in each handoff communication ?

Yes. These are the standard elements that - at a minimum - are required in each **IDEAL** handoff communication:

<b>I</b> dentify	Patient name and medical record number or date of birth; and physician name
<b>D</b> agnosis	Diagnosis and current condition
<b>E</b> vents	Recent events / changes in condition or treatment
<b>A</b> nticipated	Anticipated changes in condition or treatment, what to watch for in next interval of care, contingency plans
<b>L</b> eave	Leave time for the opportunity to ask questions and clarify information

### Is verbal handoff mandatory ?

Verbal handoff is required for all clinicians who provide continuous, 24/7 services (housestaff and other licensed independent practitioners, nurses, respiratory therapists). Verbal report may be face-to-face, phoned, or taped, and may incorporate computer-based information. When handoff is not face-to-face, the sender/off-going clinician must be available to answer questions and clarify information for the receiver/on-coming clinician. Many nursing units tape report for the oncoming shift. This is acceptable as long as the off-going nurse is physically available for questions after the oncoming nurse has listened to report. Relying on the option to call a nurse from the previous shift at home is not acceptable because there may be a reluctance to do this. Direct care providers who do not provide 24/7 services (e.g., physical therapy) may provide a written handoff progress note that includes at least the five standard elements and contact information (phone / PIC) where the receiver may obtain information or clarification.

### Is handoff of care documented ?

There is no requirement to document handoff at change of provider (nursing shift change or resident signout). Documentation is required when there is a transfer in level of care, a temporary transfer in care, and at discharge.

### What tools will assist me to document handoff ?

1. The **MIS HOC Report** is used for temporary or permanent inpatient transfers, including the patient being admitted from the E.D. The report populates patient demographics and diagnosis from existing MIS fields. The nurse prints the report from the MIS PT PRINTOUTS menu, writes recent and anticipated changes, signs the report, uses the document as a template for giving verbal report, and sends the report with the patient. There is an opportunity for any discipline to write information on the report.
2. The **Ambulatory HOC Report** (available from UVA Printing Services) is used for temporary or permanent transfer of ambulatory patients to or from a clinic or diagnostic/procedure area and when an E.D. patient is transferred to and from a diagnostic/procedure area.
3. Housestaff should always use the **MIS ORDER TRANSFER** and **ACCEPT TRANSFER** pathways to document order review and reconciliation.

### Why is it important to use the Patient Profile section of the MIS HOC Report?

A Patient Profile is required for the MIS HOC Report. Many inpatient areas rely on the Profile to standardize patient information for shift report as well as other communication needs. If your area does not currently use the Patient Profile, consider how this information can be integrated into your practice and communication strategies, and adapt your practice to populate the Profile upon admission and update it as needed.

### Have the requirements for writing a transfer note changed ?

The MIS HOC Report replaces the Nursing Transfer Note for transfer of inpatients between units. A comprehensive physician transfer note is still required when the patient changes level of care and at service rotation.

### Will the HOC Report become part of the permanent medical record ?

Both the MIS HOC Report and the Ambulatory HOC Report should be placed in the Progress Notes section of the patient's chart after completed. Health Information Services will scan both reports into the permanent medical record after the patient is discharged.

**Is handoff communication required when a patient moves from an inpatient unit to radiology or other diagnostic testing area ?** Yes. The information communicated may be limited to what is relevant to the procedure, but it is a handoff and should follow a standardized procedure. This alerts staff in the testing area that the patient is there and provides an opportunity to properly identify the patient and test to be done. *Change in requirement: A MIS HOC Report should be sent with all inpatients who travel to radiology, whether for a "simple" diagnostic test (ex. plain x-ray film) or a complex procedure (ex. interventional radiology, endoscopy). Verbal handoff is optional, based upon nursing judgment.* Staff in the diagnostic area add information, sign the same HOC Report, and send it with the patient back to the home unit.

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### How do I hand off a patient who will be transported by a non-clinical transporter ?

When a temporary or permanent patient transfer that requires handoff is completed by a non-clinician transporter, the sending clinician gives the written HOC Report to the transporter who delivers it to the receiving staff. The receiver must have the opportunity to ask questions and clarify information.

### Could handoff requirements differ between disciplines in a single patient handoff ?

Yes. Handoff is not required when the responsible clinician will not change. Example: When an ICU patient is transferred to another ICU as a boarder, and the medical service will not change, physician handoff is not required, but nursing handoff is required.

### Are there times when a patient is transferred that handoff is not required ?

Yes. Handoff is not necessary during a temporary transfer when a patient will be continuously accompanied by a clinician from the sending area. For example, when an ICU patient is accompanied to interventional radiology by an ICU nurse who will be in continuous attendance with the patient until the patient returns to the home unit, nursing handoff is not required.

### When is physician-to-physician handoff done for a patient admitted from E.D., clinic or O.R. ?

For an E.D. admission, physician handoff occurs when the admit team sees and examines the patient in the E.D. If the same physician will accept the patient on the inpatient unit, then no further handoff communication is required. Handoff occurs at the point when responsibility for the patient's care changes. The same applies to physician handoff for a patient being transferred from a clinic or the OR; if the same physician has responsibility for the patient in both locations, then no handoff occurs. However, the physician must communicate to the nursing unit or to any 'covering' physician who assumes temporary care of the patient until the admitting physician arrives.

### Can I use the same MIS HOC Report if the patient will be traveling to several locations over the course of my shift?

The patient's condition may change over time, making the information on a previous MIS Report outdated. Print a new MIS HOC Report for each temporary transfer from the unit. Exception: The patient who travels from location to location without returning to the home unit.

### Do I send a MIS HOC Report with the patient being transferred to a nursing home?

No. The MIS Home Health Referral and the physician's Discharge Summary are all that is required.

### If a clinic patient is referred to the E.D., do I need to send an Ambulatory HOC Report?

Clinic patients may be sent to the E.D. via ambulance or may be advised to travel by private vehicle. In either case, a phone call should be placed to the E.D.. If the patient travels by ambulance, the Ambulatory HOC Report is given to the ambulance personnel for delivery to the E.D. If the patient travels by private vehicle, the Report should be faxed to the E.D.

## Other Questions ?

**Educational video available on NetLearning**

Ask your manager or residency director or contact the  
Patient Safety Office (phone 4-5595 / email [dkc7a@virginia.edu](mailto:dkc7a@virginia.edu))