Patient Handoffs: What's the Problem?

- Transitions of care occur multiple times/day
- Important information may be "lost" at each transition
- The "handoff" or "handover" = transfer of information at the transition
- Bad handoffs lead to errors, higher cost, more deaths, and more complications

Good Patient Handoffs
Reduce Bad Outcomes.

Patient Handoffs: What are key features?

Systematic (same way each time)

Accurate (correct information)

Concise (no extraneous information)

Relevant (to important problems)

Timely (up to date)

Anticipates (what might happen)

Guides (says what to do)

Patient Handoffs: What are they?

Any communication involved with *transfer of care*

- A patient moves from one unit to another
- A different physician or nurse assumes care
- A patient is admitted or discharged from the hospital
- A patient will be seen by a different doctor in clinic next time

Handoffs can be verbal (in-person, telephone) or written (paper, EHR, text message)

Patient Handoffs: What they are not!

- Complete description of entire hospital course.
- List of possible differential diagnoses from admission 10 days ago.
- Guessing game for the covering person.
- List of every possible thing that could happen tonight.
- Every laboratory result since 1992.

Patient Handoffs: Reasons to Improve

Decrease errors (patient safety) and costs

Become more efficient in patient care

Requirement for training programs

Career-long skill

Patient Handoffs: Tutorial Goals

- Understand the reason(s) for systematic handoffs
- Learn some basic principles of handoffs
- Practice SBAR, a tool that improves situation awareness.
- Learn how to prepare and receive patient handoffs using I-PASS, part of ORCHID, the LA County EHR.

Patient Handoffs: What do I do now?

- Review the information in the tutorial
- Complete the exercises and questions
- Compare your answers with our answers
- Print out your certificate of completion.
- Submit your certificate to your Training Program.