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Joint Commission

What does JCAHO expect for handoffs?

Standardizing handoffs is a requirement of the 2006 National Patient Safety Goals of the Joint Commission on Accreditation of Healthcare Organizations, which took effect Jan 1.

What does JCAHO expect?

Tips were given in a Jan 25 audioconference by Joint Commission Resources (JCR) and the Association of periOperative Registered Nurses (AORN). Speakers were Chris McGreevey, RN, MS, of JCR and Doreen Wagner, RN, MSN, CNOR, representing AORN.

The handoff requirement (Goal 2e) states that organizations must "implement a standardized approach to handoff communications, including an opportunity to ask and respond to questions."

Examples of perioperative handoffs include transfer of responsibility at shift changes, breaks, or lunch and handoffs between units, such as the emergency room and OR, holding area and OR, OR and postanesthesia care unit (PACU), and PACU and patient unit. Handoffs also occur when reporting critical lab and radiology results.

What should be communicated?

The minimum list, according to JCAHO's implementation guidelines for the 2006 goals, includes the patient's:

- diagnosis
- current condition
- changes in treatment
- recent or anticipated changes
- what to watch for.

Additional items might include the patient's:

- current medical status
- resuscitation status
- current medications
- allergies
- recent or pending lab values
- problem list
- to-do list for incoming physician or nurse.

What will surveyors look for?

"Surveyors will be looking for consistency in the staff's responses to determine if the organization has developed a standardized approach and communicated it effectively in the organization," McGreevey said. If surveyors hear inconsistent responses, they might want to know more about staff training and education materials.

This doesn't mean the handoff has to be the same everywhere, she added. Different departments or physician groups might use different approaches.

Surveyors may directly observe some handoffs. "They will listen to see if the handoff is interactive—are the participants asking and responding to questions?" she said.

Strategies for improving handoffs

Wagner discussed strategies organizations can use to improve handoffs:

- Organize a multidisciplinary team to help develop policies and procedures.
- Discuss barriers to communication and develop solutions. For example, if reports are given in places that are noisy or distracting, how can that situation be improved?
- Include the entire team. Discuss barriers to handoff communication that may arise because of hierarchies, for example, between residents and attending physicians and physicians and nurses. Make sure there is leadership backing to address these barriers.
- Address language barriers for clinicians who do not have English as their first language. Promote use of accepted abbreviations, both when speaking and writing. Continue to use techniques like repeating key parts of verbal reports to confirm information.
- Some organizations are using technology to improve communication. Examples are integrated documentation software and patient tracking systems, such as electronic greaseboards, that convey information about patients' locations and status.
- Ensure that the staff has time to complete handoffs and be sure information is accurate.
- Develop a standardized handoff tool. Some are using the easy-to-remember acronym SBAR:
  - **S**ituation
  - **B**ackground
  - **A**ssessment
  - **R**ecommendation.

  Another acronym is CUBAN:
  - **C**onfidential
  - **U**ninterrupted
  - **B**rief
  - **A**ccurate
  - **N**amed personnel.

Go beyond the checklist

Checklists are not the only answer to standardizing handoffs, Wagner cautioned. "They may save time, but they don't provide context and significance of the data," she said, which is why it's important to provide an opportunity to ask questions and allow for responses. ❖

More information on the National Patient Safety Goals is at www.jcaho.org.

What is a handoff?

JCAHO defines a handoff as a "real-time interactive process of passing information from one person (or team) to another for the purpose of ensuring continuity and safety of a patient's care." The primary objective is to provide accurate information about a patient's:

- care, treatment, and services
- current condition
- recent or anticipated changes.

Attributes of effective handoffs

- Listening without interrupting or talking over the other person
- Allowing for questions and comments to provide context
- Covering pertinent safety issues, such as any near misses during the patient's care

- Describing potential problems
- Verifying information by repeating or reading it back, especially if the handoff is not face to face
- Minimizing interruptions
- Providing opportunities to review the patient's pertinent historical data.