Stanford PCCM Internal Handoff Processes v 1.0

(last updated 6/18/24)

In order to sustainably improve our verbal and written handoff processes, the expectation is that all members of our division will adhere to these guidelines to the best of their ability. We recognize this will be an iterative process and welcome feedback for future revisions.

Week to Week:

Friday Sign-out: Intended as high-level handoff, discussion of challenging clinical questions, decision points. 2nd and 3rd year fellows will discuss patients when on primary service. Attendings will role model for fellows when a first year fellow is on primary service (this includes advanced fellows).

PICU Attending: Attend Friday signout. Verbal handoff between oncoming/offgoing attending on the last day of service with updates (or Monday AM if offgoing on call). Off-going reaches out to on-coming.

Fellows: Attend Friday signout (if not on nights, vacation, or busy in the CVICU). Verbal handoff between oncoming/offgoing service fellows. Offgoing week-day service fellow reaches out to oncoming week-day service fellow (ideally on the last day of service week). Sunday fellow also reaches out to oncoming service fellow for any weekend updates.

Frontline Providers: Off-going frontline providers to provide written handoff email to APP/hospitalist providers on their last day of service (and includes phone number for opportunity for verbal communication). Offgoing frontline provider reaches out to oncoming frontline provider.

*Handoff, verbal or written is not intended to fully prepare the oncoming provider to care for the patient. The expectation is that the oncoming provider is going into handoff prepared to assume care (through reading the chart, etc).

Daily:

New Admissions/Transfers: Buffer attending/fellow: After accepting new admissions/transfers and with the charge nurse, deciding which team they will go to, buffer attending/fellow should find the primary team's attending,fellow and frontline provider to provide in person handoff re: the coming transfer/admission.

Frontline providers/Fellows Afternoons: Fellows should run the list with the frontline providers in the late afternoon (ie ~3:30 PM) before signout (ideally walking around the unit with the frontline provider). C team providers should run the list with the C team attending as well.

Fellows should review written EPIC handoff with frontline providers and remind them that is the responsibility of the frontline provider to ensure handoff is accurate and up to date each day.

Attending End of Day: 4:30 PM Rapid Walk Signout (ie 1-2 min per patient) between oncoming/offgoing attending. Fellows to join whenever able to learn (or practice if senior fellow) attending level sign out and ensure fellow/attending are aligned for night goals. (***Fellow sign out is at 5 PM so fellows may need to leave attending signout if that is not complete by 5 PM) . Night shift goals and to-do's should be clarified.

Fellows End of Day: 5 PM: Concise signout to the oncoming fellow (A to be done by 530 PM for C team signout). Buffer fellow to stay until A/B/C fellow signout complete. Pretending can sign out to oncoming night attending at 430 PM if unit census/acuity allows. Night shift goals and to-do's should be clear.

Overnight Attending + Fellows: Early evening (ie ~7 or 8PM) rapid walk rounds with attending and night float fellows (ideally both A and B) for all patients. The primary goal of this is to ensure alignment between attending and fellows re: goals for the night and promote fellow situational awareness of the whole unit. Hence, the fellow need not have seen the patients prior to this nor is the intention to do multidisciplinary rounds. Night attending should also incorporate teaching during this time. This can be done in 15-30 minutes for the whole unit with 1-2 minutes per patient.

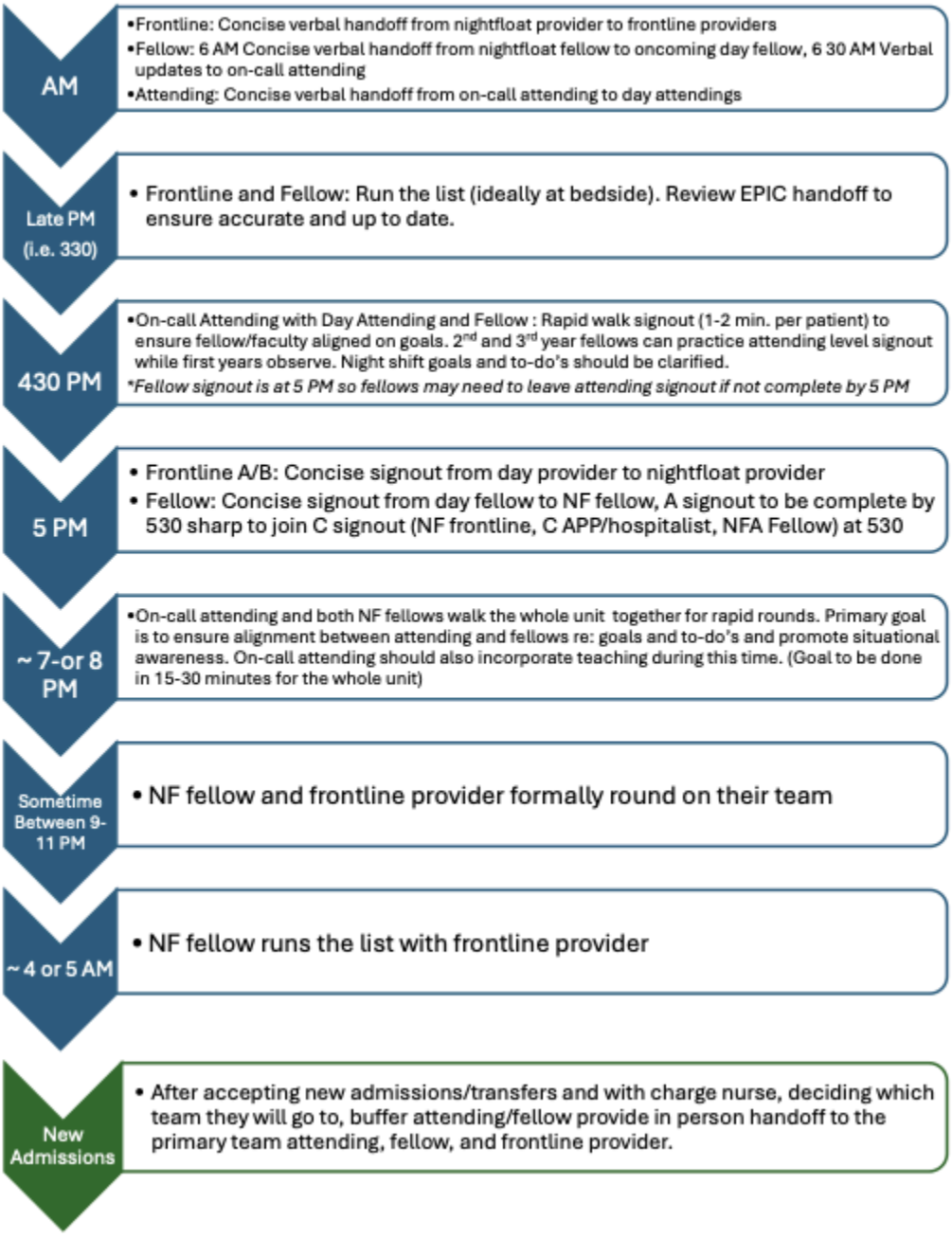
Night fellows :

- As above, early evening (ie ~7 or 8 PM) rapid walk rounds with on-call attending (ideally both A and B fellows at the same time).
- Night fellow has separate formal rounds with frontline provider for their team (ie sometime around 9-11 PM depending on unit acuity/census). Night shift goals and to-do's should be clarified with the multidisciplinary team (including RNs, RTs etc)
- Night fellow should follow escalation guidelines and communicate with the overnight attending (ie text with new patient arriving etc)
- Night fellow should run the list and review goals and to-do's with the overnight frontline provider towards the end of the shift (ie 4-5 AM) prior to signing out to the day fellow
- Night fellow should check in with overnight attending after signing out to the day fellow (ie 630 AM) to provide any overnight updates. This should be verbal in person or over the phone. (This should not be via text).

Written handoff: Expectation that written hand off is updated daily and is accurate. Fellows to review with frontline provider each day when running the list in the afternoon. APP/hospitalist team on C can discuss with C team attending as needed.

Not covered by this document:
Buffer to PICU team, ER to PICU, floor to PICU, OR to PICU etc

Stanford PCCM Internal Handoff Process: Daily



Stanford PCCM Internal Handoff Process: Weekly

Friday Sign-out: Intended as high-level handoff, discussion of challenging clinical questions, decision points. 2nd and 3rd year fellows will discuss patients when on primary service. Attendings will role model for fellows when a first year fellow is on primary service (this includes advanced fellows).

Reference:Joint Commission Handoff Guidelines (see #3 re: verbal handoffs):

The Joint Commission

8 Tips for High-quality Hand-offs

All caregivers can make high-quality hand-offs. Here's how.

What is a hand-off?

A hand-off is a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care.

01

Determine the critical information that needs to be communicated face to face and in writing. Cover everything needed to safely care for the patient in a timely fashion.

02

Standardize tools and methods used to communicate to receivers. These can be forms, templates, checklists, protocols, and mnemonics, such as I-PASS (stands for Illness severity, Patient summary, Action list, Situation awareness and contingency plans, and Synthesis by receiver).

03

Don't rely solely on electronic or paper communications to hand-off the patient. If face-to-face communication is not possible, communicate by telephone or video conference. This allows the time and opportunity to ask questions.

04

If information is coming from many sources, combine and communicate it all at one time, rather than communicating the information separately.

05

Make sure the receiver gets the following minimum information:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Dated laboratory tests
- Dated vital signs

06

When conducting hand-offs or sign-outs, do them face to face in a designated location that is free from non-emergency interruptions, such as a "zone of silence."

07

When conducting a hand-off, include all team members and, if appropriate, the patient and family. This time can be used to consult, discuss, and ask and answer questions. Remember not to rely only on patients or family members to communicate vital information on their own to receivers.

08

Use electronic health records (EHRs) and other technologies (such as apps, patient portals, telehealth) to enhance hand-offs between senders and receivers — don't rely on them on their own.

What is the standard?

Provision of Care standard PC.02.02.01, element of performance (EP) 2: The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.

See Sentinel Event Alert Issue 58, "Inadequate hand-off communication," for more information, resources and references.

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