Transitions Between Hospital and Home

Close to Time of Discharge: Ensure Personal Clinician to Clinician Information Transfer

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Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow-up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices.

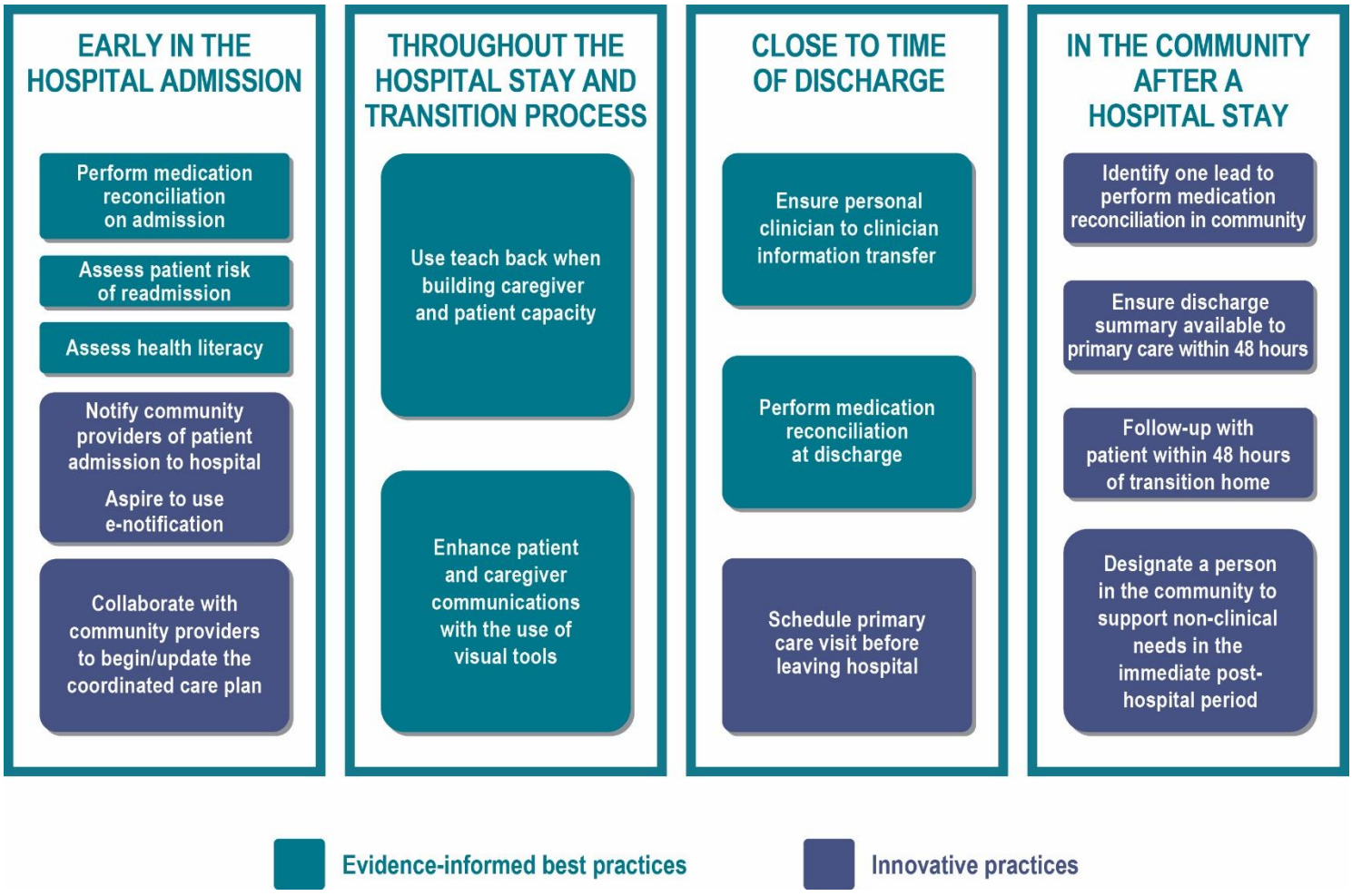

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Evidence-Informed Best Practice

As patients who have multiple conditions and complex needs transition from clinician to clinician (e.g. most responsible physician to primary care), it is critical that information about their treatment, care plan, and goals go with them. To improve information transfer, patients should be involved whenever possible so that they can better advocate for their own care preferences as part of the care process. Various tools and techniques can help streamline the handoff process and establish standardized communications. Health Links should consider using structured tools such as mnemonics, templates or checklists to ensure information is not lost during the clinician to clinician transfer process.

Tools and Resources

In an environmental scan and literature review, the following tools were found to be highly effective and commonly used for clinician to clinician transfer of information. The decision to implement or administer one of these tools must be considered alongside other locally contextually relevant information.

Ensure Personal Clinician to Clinician Information Transfer		
Name of Tool	**Overview**	**Considerations/Links**
I PASS The BATON	**I PASS The BATON** mnemonic facilitates the process for handoffs and health care transitions. The transfer of information during transitions in care across the continuum allows for the health care provider to have an opportunity to ask questions, clarify and confirm the transfer.	• To enhance performance and patient safety, this strategy designed to enhance information and exchange is available at the ***Agency for Healthcare Research and Quality***: http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html
SBAR	**SBAR** (Situation, Background, Assessment, and Recommendation) is an effective and efficient way to communicate information developed by Kaiser Permanente. This method effectively enhances handovers between shifts or between staff in the same or different clinical areas.	Toolkits can be found at: • The ***Institute for Healthcare Improvement***: SBAR Toolkit can be found at: http://www.ihi.org/resources/pages/tools/sbartoolkit.aspx • The ***University Health Network*** (Toronto Rehabilitation Institute): Toolkit can be found at: http://www.uhn.ca/TorontoRehab/Education/SBAR/Documents/SBAR_Toolkit.pdf
Whiteboard Communication	**Whiteboard communication** can serve as a communication tool between clinicians and as a mechanism to engage patients in their care. Effective use of a patient whiteboard requires a patient-centered approach to care.	• Whiteboards have the potential to improve patient flow, but a planned approach to their use is required to ensure information is up-to-date. Staff buy-in and patient privacy need to be addressed. Standard operating protocol for whiteboard communication has been developed jointly by ***Griffith University and Murdoch University*** in Australia and can be found at: http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/SOP-Whiteboard-Comms.pdf

Additional Resources

For additional information on Quality Improvement, please visit: http://qualitycompass.hqontario.ca/portal/getting-started.

For additional information on Clinician to Clinician Information Transfer, please visit:

- *Saskatchewan's Health Quality Council Patient Flow Toolkit (Refer to Module 3)* http://hqc.sk.ca/Portals/0/Patient%20Flow%20Toolkit%20April%202016.pdf?ver=2016-05-05-093543-867
- *The American Medical Association* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/resident-fellow-section/rfs-resources/patient-handoffs.page

References

1. Arora V, Johnson J, Lovinger D, Humphrey H, Meltzer D. Communication Failures in Patient Sign-Out and Suggestions for Improvement: A Critical Incident Analysis. Qual Saf Health Care. 2005;14:401-407

2. Haig KM, Sutton S, Whittington J. National Patient Safety Goals. SBAR: A Shared Mental Model for Improving Communication Between Clinicians. Jt Comm J Qual Patient Saf. 2006;32(3):167-175.