I-PASS

BETTER HANDOFFS. SAFER CARE.

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Time line and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Reference: http://www.uthsc.edu/graduate-medical-education/policies-and-procedures/documents/handoffs-and-transition-of-care.pdf

Evaluation Form Verbal Handoff
1. The hand-off is face to face?
2. The hand-off took place in a setting free of interruptions and distracting noises?
3. Was the level of acuity identified at the onset of hand-off process?
4. Was the use of standardized language i.e. stable, watcher unstable used to highlight the sickest patient?
5. Code status is mentioned if the patient is not full code?
6. Was a succinct patient summary provided (reason for admission, hospital course, relevant new events, and global plan for hospitalization)?
7. Includes up-to-date task list and specification of “nothing to do” if no action items are anticipated.
8. Was anticipatory guidance (contingency plan) and rationale provided?
9. Did the receiver have an opportunity to ask questions to ensure understanding of hand-off?
10. Did the receiver have an opportunity to confirm understanding of hand-off?
WRITTEN HANDOFF - EMR Notes
11. Is there a written hand-off i.e. one-note, EMR, word document, or hand-written notes?
Does the written hand-off contain the following?
12. Responsible attending physician name and contact information?
13. Patient identifiers (name/age/room number)
14. DNR status
15. Pertinent diagnosis
16. Updated medication list
17. Allergies
18. Task list (lab, x-rays, procedure results)
19. Contingency plan for how to handle anticipated problems

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