APPENDIX: 25

TITLE: Patient Hand-Off Guidelines

REVISED: December 01, 2022

Purpose: Patient “hand offs” between providers have been identified as a major cause of downstream medical errors. Therefore, these guidelines provide a framework to standardize the “hand off” between regional EMS providers to reduce errors and improve patient safety and outcomes.

The use of these scripted guidelines will provide for a more cohesive and organized standard of care for the communication of both EMS providers and hospital staff throughout the region.

I. General Principles

- Proper hand offs are a crucial patient safety practice. These principles would be applied to the extend practical, to any handoff of patient care between providers.
- The patient handoff is a critical period for information transfer and should be given primary attention of all providers involved.
- A typical 30-60 second “Moment of silence” is often instituted during these handoffs, if possible.
- The provider giving the information should not be interrupted or asked questions until the initial report is complete, then clarifying questions may be asked.

II. Pre-Arrival Report:

This brief (30– 45 second) pre-arrival report is intended to provide essential information to the receiving facility to prepare the appropriate resources for the patient.
Information should be limited to the most essential “high points’ with the understanding that a more complete hand off (including Medications, Allergies, PMH, etc) will be given to the team of providers directly caring for the patient at the bedside.

Call-in / Bedside Template	Examples?
D: Designator and Demographics	Unit ID Patient Age and Gender
M: **Mechanism** of Injury/Illness	Chief Complaint? Minor Trauma? CODE STEMI? CODE STROKE? CODE CRITICAL? PRORITY TRAUMA?
I: Most Severe **Injuries /Illness** Presentation	Include pertinent TSE /Code critical criteria Include Stroke assessment/VAN positive status.
S: Vital **Signs**	Last set of vitals AND lowest B/P (if applicable)
T: Major **Treatments**	Summary of interventions in route.
FYI: For Your Information (Any other Pertinent information}	ETA Need for Security Specialty Equipment (Bariatric, Lifting help, etc) Cardiologist Name?

Specialty “Radio/Phone Call-In” to area Hospitals.

Specialty radio/phone “Codes” will be for the patient meets certain predetermined clinical categories, typically in line with the State of Idaho “Time Sensitive Emergencies” criteria. These include:

- “Code STROKE”
  - This designation is used to notify appropriate receiving hospitals that the patient meets certain criteria outlined in Protocol M-4 Adult CVA and G-3 Hospital Destination Protocol
  - Example: "*Medic 13 enroute with a 34 y/o female Code STROKE Patient*"
- “Code STEMI”
  - This designation is used to notify appropriate receiving hospitals that the patient meets certain criteria outlined in "*C-4: S.T.E.M.I. Protocol*".
  - Example: *"Medic 13 enroute with a 64 y/o male Code STEMI Patient."*

- "Priority Trauma" (typically followed by a "priority category"
  - This designation is used to notify appropriate receiving hospitals that the patient meets certain criteria outlined in "*Appendix 16 – Trauma Priority Criteria*".
  - Example: "*Medic 13 enroute with a 64 y/o male Priority Three trauma patient*."
- "Code CRITICAL"
  - This designation is used to notify appropriate receiving hospitals that the patient meets certain criteria for increased morbidity and mortality, ***but who otherwise don't fall under one of the other Time Sensitive Emergency (T.S.E.) categories outlined above***.
  - Example: "*Medic 13 enroute with a 29 y/o female Code Critical Patient*."

III. Bedside Handoff Report.

This 45 to 60 second verbal report by the EMS provider will follow the same guideline template that is used for the **"Pre-Arrival Report"**

Call-in / Bedside Template	Examples?
D: Designator and Demographics	Unit ID Patient Age and Gender
M: **Mechanism** of Injury/Illness	Chief Complaint? Minor Trauma? CODE STEMI? CODE STROKE? CODE CRITICAL? PRORITY TRAUMA?
I: Most Severe **Injuries /Illness** Presentation	Discussion of assessment findings Include pertinent TSE /Code critical criteria Include Stroke assessment/VAN positive status.
S: Vital **Signs**	Last set of vitals AND lowest B/P (if applicable
T: Major **Treatments**	Detailed discussion of interventions in route. Include ongoing interventions (vent settings, IV fluids, etc). Include total amount of medications administered and time of last administration of medications.
FYI: For Your Information (Any other Pertinent information}	ALLERGIES DNR/DNI/POST status Mandatory Reporting concerns (i.e. Abuse, etc)

	Need for Security/Sitter for fall risk Specialty Equipment Cardiologist Name? A.M.P.L.E.Hx Family/Social considerations Location of personal belongings/paperwork

IV. After the Handoff.

The lead EMS provider should confirm understanding and answer any questions as needed. In the case of high acuity or specialty patients, the EMS provider and team should standby until hospital team has completed their initial assessment to be readily available to answer new questions.

V. Handoff between healthcare providers

While rare, when receiving a patient from another healthcare provider either in the field (from a first responding unit) or in hospital (i.e. during a emergent interfacility transport) providers on both sides of the transfer should use the D-MIST-FYI format as described above.