Purpose:	The purpose of this procedure is to provide health care team members with an effective and consistent communication tool (IDRAW) to support the accurate and timely exchange of patient/client information during routine, nonurgent handover situations. As outlined by Accreditation Canada, this process will minimize misunderstandings, and support quality patient/client safety and care (Accreditation Canada Required Operational Practice (ROP) *Information Transfer at Care Transitions*, Handbook 2016, p. 19). This procedure: • Describes the ideal processes for effective verbal and/or face-to-face interactive communication of patient/client information and transfer of accountability at handovers (e.g., admission, change in care provider, transfer, and discharge) using IDRAW: **I** Identify Patient **D** Diagnosis and/or Current Problems **R** Recent changes **A** Anticipated changes **W** What to watch for
Scope:	• Direct Clinical Care Staff (e.g. Nursing, Allied Health, students/residents) • Providers (e.g. Physicians, Nurse Practictioners, Midwives) • Clinical Support Staff (e.g. NUAs, Admitting Clerks, any individuals supporting clinical operations) • Other Island Health Partners (i.e. agents, academic partners) Environment: • All programs and services across Island Health, including contracted services/relationships.
Outcomes:	Comprehensive and timely exchange of patient/client information during handovers. Consistent use of a communication tool (IDRAW) during the transfer of patient/client information and accountability at care transitions.

1.0 Procedure

A care transition includes any point of patient/client transfer or any point at which a transfer of accountability occurs between care team members and to the patient/client or responsible family members at discharge. Information transfer and communication at handovers must occur at the following care transitions:

- Admission
- Change in accountability between team members (e.g. handover at shift-to-shift, rest periods, change of care provider etc.)
- Patient/client transfer (e.g., patient/client transfer points within hospitals, facility and/or services inclusive of Acute, Residential, Facility and/or Community settings)
- Discharge

Accreditation requirements and Island Health standards inform the processes necessary to standardize the verbal transfer of patient/client information at care transitions. To support these requirements and standards, healthcare team members must:

- Ensure that handovers of patient/client health and care information are completed in a timely manner.
- use a consistent approach (e.g., the IDRAW tool) between sender and receiver to transfer patient/client information during times of transition.

1.1 Effective Handovers using the IDRAW tool:

1. Prior to contacting the receiver, the sender reviews and confirms the key patient/client information on the plan of care and patient/client record.
2. The sender determines a suitable location (e.g., time, place, face-to-face or telephone call) to limit interruptions, maintain privacy and security.
3. The sender plans the routine handover using the IDRAW tool and organizes patient/client information into five key topics of discussion.
4. The sender communicates clearly and concisely to the receiver by:
    - Using clear language and voice
    - Not using abbreviations and/or terms that can be misinterpreted
5. During the handover of care and accountability, the receiver confirms receipt of patient/client information.
6. The sender documents the date, time and who received the handover report / transfer of accountability in the patient/client paper chart or electronic health record (EHR).

1.2 Patient/Client Information Shared During Handovers:

In order to provide a snapshot of pertinent patient/client information and to support the safe and appropriate transfer of patient/client information and accountability, the following IDRAW acronym is used to support standardized verbal communication during interactive and ideally face-to-face handovers:

I Identify Patient
D Diagnosis and/or Current Problems
R Recent changes
A Anticipated changes
W What to watch for

IDRAW Template for Handover		
	Key Focus Area	Suggestions for Discussion
I	Identify	• Identifies patient/client using two (2) patient/client identifiers. • Provides the MRPs contact information.
D	Diagnosis	• Admitting diagnosis and date • Estimated length of stay • Current clinical problem(s) • Reason for transition • Patient/client goals • In some clinical settings, may also include allergies; medications; test results; procedures; and/or advance directives.
R	Recent Changes	▪ Brief summary of the last 24 hours of care. ▪ Provide what is important for the receiver to know about patient/client

		(e.g., most recent patient/client assessment changes). ▪ Most current vital signs
A	Anticipated Changes	▪ Identify tasks that need to be completed for the patient/client. ▪ Provide a picture of what the next few hours might look like for the patient/client.
W	What to Watch for	• Identify potential patient/client risks (e.g., safety concerns) that may occur during and/or shortly after transition. • Receiver should be encouraged to ask questions to clarify understanding.

**please see Appendix A for IDRAW worksheet example*

2.0 Definitions

Academic Partners: Includes both private and public Post-Secondary academic and training institutions/programs with an Educational Affiliation Agreement, and their affiliated faculty, students, residents and/ or researchers.

Agents: Third-party individual(s), or organization(s), who have a formally authorized clinical, academic or business relationship with Island Health, excluding employees. Examples of Agents may include, but are not limited to, regulated health care providers, researchers, service providers, contractors, sub-contractors, vendors, suppliers, etc. The term Agent is used for the purpose of this policy only and does not designate/indicate an employer-employee relationship exists between Island Heath and the Agent. Agents, by virtue of their relationship with Island Health, are deemed to have the potential to access confidential information, commensurate with their functional role with, or in relation to, Island Health.

Care Transitions: Are critical points in the care system during which the communication and/or transfer of information is vulnerable, these include handovers at: shift changes, patient transfers, discharges and referrals

Clinical Support Staff: Those not providing direct patient/client care such as: nursing unit assistant, booking clerk, admitting clerk, scheduling clerk, health record, pharmacy dispensary, any individuals supporting clinical operations.

Direct Clinical Care Staff: Includes all members of the allied health team (e.g., Physiotherapist, Speech Language Pathologist, Rehab Assistant, Occupational Therapist, Pharmacist, Social Work, Dietitian, and Respiratory Therapist) and the nursing team (e.g., Registered nurse, Registered Psychiatric Nurse, Licensed Practical Nurse), Health Care Assistants, and Students.

Electronic Health Record (EHR): Collective electronic medical records of a patient/client or a population of patient/clients.

Nonurgent (or routine) communication: Is communication which does not require an immediate response (e.g., within one hour or less) and/or does not include urgent clinical patient/client information

Patient/client: Refers to patient, client, resident or person in receipt of healthcare services within Island Health.

Provider: Includes Physician, Midwife, Nurse Practitioner, respective student populations (i.e. medical students and residents).

Receiver: Healthcare clinician, student, and/or provider receiving patient/client information during communication at care transition.

Sender: Healthcare clinician, student, and/or provider giving patient/client information during communication at care transition.

Urgent Communication: Communication which requires a response within one (1) hour or less; compelling or requiring immediate action or attention.

3.0 Related Island Health Standards and Resources

- Respectful Workplace
- Cultural Safety
- Code of Conduct
- 9.3.3PR Discharge of a Patient/Client Procedure
- 9.3.2 PR Transfer of a Patient/Client Procedure
- 9.1.42PR Adult Admission History Procedure
- 9.6.1P Information Transfer at Care Transitions
- 9.8.1PR SBAR - Urgent Information Transfer and Communication Procedure
- Confidential Information – Privacy Rights of Personal Information Policy
- Medical Staff Rules for the Vancouver Island Health Authority
- Communicating and Assessing Risk of Violence Policy
- Confidential Information Management Code of Practice Policy
- 16.5.1 Positive Patient Identification (PPID) at Point of Registration Policy
- 16.5.2 Positive Patient Identification (PPID) at Point of Care Policy
- 16.5.3 G Positive Patient /Client Encounter Selection Guideline

4.0 References

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Appendix A:

IDRAW Worksheet example to support transfer of care at shift change:

IDRAW Focus Area Example	Suggestions/ Notes: after review of patient/client plan of care
Identification: ▪ Patient/client's full name ▪ DOB / age / gender ▪ MRP	
Diagnosis: ▪ Admitting diagnosis / relevant history ▪ Current condition ▪ Problems ▪ Risks: Falls/Precautions/Allergies/Violence	
Recent Changes (baseline vs current status): ▪ Most recent patient assessment ▪ Most current vital signs ▪ Functional status (48/6 or 24/7 areas) ▪ A brief summary of the last 24 hours of care ▪ What is important for the receiver to know?	
Anticipated Changes: ▪ Outstanding tasks - What the next few hours will look like for this patient/client ▪ Potential abnormal test and/or assessment results	
What to Watch for: ▪ Provide potential patient/client risks that may occur during and/or shortly after transition. ▪ Any concerns	