

## Safe Transitions Gap Analysis

Safe transitions are dependent upon structures and processes which have been identified as the Safe Components and Actions. Implementation of the safe transitions program should start with a gap analysis to examine how your organization is currently performing. The gap analysis provides insight into the needs for improvement toward safe transitions of care.

SAFE Component	Specific Action	Assessment Question	Yes	No
<p><b>Safe transition teams</b></p> <p style="font-size: 48px; text-align: center; color: #ccc;">S</p>	<ul style="list-style-type: none"> <li>• Provide support and expectations for SAFE TRANSITIONS champions</li> <li>• Adopt an interdisciplinary team approach to SAFE TRANSITIONS with a designated coordinator</li> <li>• Engage key stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>• Senior Leadership has identified a physician champion(s) and/or senior executive for SAFE TRANSITIONS</li> <li>• Senior Leadership has identified an operational champion(s) for SAFE TRANSITIONS (e.g. Case management Director, Social Worker, Nursing Leader)</li> <li>• The facility has a process in place to partner the physician and operational champions</li> <li>• Senior Leadership has defined roles, set expectations and provides support for the champion(s)</li> <li>• The facility adopts a team approach to safe transitions with an interdisciplinary team to oversee and support the SAFE TRANSITIONS work</li> <li>• The facility has a designated coordinator to oversee SAFE TRANSITIONS implementation (e.g. schedule team meetings, plan staff education)</li> <li>• Individual roles in SAFE TRANSITIONS are clearly defined</li> <li>• Stakeholder representation on team includes all transition settings</li> </ul>		
<p><b>Access to information</b></p> <p style="font-size: 48px; text-align: center; color: #ccc;">A</p>	<ul style="list-style-type: none"> <li>• Verify the completion of SAFE TRANSITIONS</li> <li>• Audit the effective completion of SAFE TRANSITION</li> <li>• Measure the outcomes of SAFE TRANSITIONS</li> <li>• Evaluate the SAFE TRANSITIONS efforts for learning opportunities</li> </ul>	<p>Data Collection</p> <ul style="list-style-type: none"> <li>• The facility has a process in place to audit the completion of SAFE TRANSITIONS through audits</li> <li>• The facility has developed standard criteria for auditors</li> </ul> <p>Data Analysis</p> <ul style="list-style-type: none"> <li>• The facility has a process in place to review and analyze data on a regular basis for learning and improvement opportunities</li> <li>• Data is shared within and across teams on a regular basis</li> <li>• Data is shared with senior leadership on a regular basis</li> <li>• Data is shared with the facility's medical staff on a regular basis</li> </ul>		
<p><b>Facility expectations</b></p> <p style="font-size: 48px; text-align: center; color: #ccc;">F</p>	<ul style="list-style-type: none"> <li>• Set expectations for implementation of SAFE TRANSITIONS for any transition</li> <li>• Expect staff to "speak up" when they become aware of a patient safety issue related to transitions of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Senior leadership has set clear expectations for effective completion of SAFE TRANSITION prior to any transition</li> <li>• Senior leadership has clearly communicated that all staff are expected to speak up and will be supported in speaking up, when safety issues are noted.</li> <li>• The facility has a process in place to institute hard stop for transitions if required components of a safe transition are not addressed/</li> </ul>		
<p><b>Educate staff and patients</b></p> <p style="font-size: 48px; text-align: center; color: #ccc;">E</p>	<ul style="list-style-type: none"> <li>• Provide SAFE TRANSITIONS education for all staff involved in transitions, including practitioner.</li> <li>• Educate patients and families on their role in SAFE TRANSITIONS</li> </ul>	<ul style="list-style-type: none"> <li>• Expectations and supporting education have been incorporated into orientation for new physicians and other practitioners involved in transitions</li> <li>• Ongoing SAFE TRANSITIONS staff education is provided at least annually</li> <li>• Patient/family safe transition education tools are disseminated as appropriate</li> </ul>		

# TRANSITIONS

Principle/Standard	Specific Action	Assessment Questions	Yes	No
<p><b>Accountability</b> All transitions must include records that contain core elements; additional elements should also be included as appropriate for individual patients.</p>	<ul style="list-style-type: none"> <li>• Create communication tool (form, report, electronic tool) that contains core and additional elements for each type of transition</li> <li>• Complete Transitions of Care Transfer Form</li> <li>• Hold team members accountable when the SAFE TRANSITON is not completed regardless of whether or not an adverse event occurs</li> </ul>	<ul style="list-style-type: none"> <li>• The facility requires AND has a designated form that contains core elements for each appropriate transition setting               <ul style="list-style-type: none"> <li>○ Hospital to SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living</li> <li>○ SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living to Hospital</li> <li>○ Emergency Department to Hospital, SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living</li> </ul> </li> <li>• The facility requires AND has a designated form that contains additional elements for each appropriate transition setting               <ul style="list-style-type: none"> <li>○ Hospital to SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living</li> <li>○ SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living to Hospital</li> <li>○ Emergency Department to Hospital, SNF, LTAC, Hospice, Home Care, Group Home, Assisted Living</li> </ul> </li> </ul>		
<p><b>Responsibility</b> At every point during care transition, patients and their families must know who is responsible for care and how to contact the caregiver</p> <p>Transition responsibility belongs to the sending clinicians and organizations until the receiving practitioners confirm assumption of responsibility</p>	<ul style="list-style-type: none"> <li>• Create communication mechanism to assure patient and family know who is responsible for care</li> <li>• Provide caregiver contact information to patient and family</li> </ul>	<ul style="list-style-type: none"> <li>• The facility requires AND has a designated mechanism of communication to provide caregiver contact information to patients and their family</li> <li>• The facility has a process in place to confirm assumption of responsibility by receiving facility</li> <li>• The sending practitioner is available for clarification with issues of care within a reasonable timeframe after the transfer has been completed, and this timeframe should be based on the conditions of the transfer settings.</li> </ul>		
<p><b>Coordination of Care</b> As the hub of care, coordinating clinicians must provide timely communication to other care providers</p>	<ul style="list-style-type: none"> <li>• Establish timelines for communication and information exchange between sending and receiving practitioner</li> <li>• Establish format of communication and information exchange.</li> </ul>	<ul style="list-style-type: none"> <li>• Established timeline of communication occurs in an amount of time that will allow the receiving provider to effectively treat the patient.</li> <li>• The timeliness of this communication is consistent with the patient's clinical presentation and the urgency of the follow-up required.</li> <li>• The format of communication includes one of the following: call, voice mail, fax, or other secure, private, and accessible means including mutual access to an electronic health record</li> </ul>		
<p><b>Family Involvement</b> Patients and families must be involved in, including information needed to identify patients medical care homes and coordinating clinicians</p>	<ul style="list-style-type: none"> <li>• Engage patient and family in transition process</li> <li>• Recognize the central role patient and family play in executing transition care plan</li> </ul>	<ul style="list-style-type: none"> <li>• A section on the transfer record is devoted to communicating a patient's preferences, priorities, goals, and values (eg, the patient does not want intubation)</li> </ul>		

Principle/Standard	Specific Action	Assessment Questions	Yes	No
<p><b>Communication</b> Clinicians or institutions must provide a clear and direct communication infrastructure, including transition records, treatment plans, and follow-up expectations</p>	<ul style="list-style-type: none"> <li>• Develop communication infrastructure.</li> <li>• Use standard communication formats established for community</li> <li>• Provide current and ongoing access to a patient's medical history with the ability to modify information as a patient's condition changes.</li> </ul>	<ul style="list-style-type: none"> <li>• Communications between practitioners and between practitioners and patients and families/caregivers is secure, private, Health Insurance Portability and Accountability Act-compliant, and accessible to patients and those practitioners who care for them.</li> <li>• Communication is 2-way with an opportunity for clarification and feedback.</li> <li>• Communication format agreed to by transition settings is used for transition communication</li> <li>• Patients have access to their information.</li> </ul>		
<p><b>Timeliness</b> Transition teams must provide information feedback and feed forward (based on transition settings, patient circumstances, level of acuity and transition responsibility)</p>	<ul style="list-style-type: none"> <li>• See Coordination of Care</li> </ul>	<ul style="list-style-type: none"> <li>• See Coordination of Care</li> </ul>		
<p><b>Standards and metrics</b> Standard communication formats for care transitions should be adopted, implemented and used for accountability and continuous quality improvement</p> <p>Standardized methods of measuring outcomes should be implemented across healthcare setting.</p>	<ul style="list-style-type: none"> <li>• Develop policies and procedures for SAFE TRANSITIONS</li> <li>• Establish standardized discharge pathway</li> <li>• Audit the effective completion of SAFE TRANSITION</li> <li>• Measure the outcomes of SAFE TRANSITIONS</li> <li>• Evaluate the SAFE TRANSITIONS efforts for learning opportunities</li> <li>• Establish metrics for monitoring and improving transitions,</li> </ul>	<ul style="list-style-type: none"> <li>• Metrics/measures are evidence-based, address documented gaps, and have a demonstrated impact on improving care (complying with performance measure standards).</li> <li>• Results from measurements using standardized metrics leads to continuous improvement of the transition process.</li> <li>• Examples to consider: readmission rate, number of follow-up phone calls, medication errors, patient satisfaction, ER visits.</li> </ul>		

Practitioner refers to licensed independent practitioner, e.g. physician, advanced practice registered nurse, physician assistant.