

Handoffs - Summary

Teaching Objectives:

1. To recognize effective vs. ineffective handoffs.
2. Identify the components of an effective handoff.
3. To understand the importance of communication.

The issues around communication:

- The Institute of Medicine estimates that up to 100,000 patients die annually in U.S. hospitals secondary to errors.
- Problems with communication, continuity of care, or care planning is cited as the root cause in >80% of sentinel events (event that is unexpected and leads to the risk of or actual death, serious physical or psychological injury).
- A review of 28 hospitals in Australia found that errors in communication are associated with twice as many deaths as clinical inadequacy.
- A study found that coverage by a second team of residents is a strong predictor of adverse outcomes.

Impetus for change:

- 2009 Joint Commission Patient Safety Goal: "The primary objective of a handoff is to provide accurate information about a patient's care, treatment, and services; current condition; and any recent or anticipated changes. The information communicated during a handoff must be accurate in order to meet patient safety goals."
- Increasing shift work, higher patient turnover, the specialization and compartmentalization of health care, and multiple points of transition (MD to MD, resident to resident, RN to RN, etc).
- Studies finding failures in intern handoffs in both:
 - What was communicated: failure to report active medical problems, treatments, medications, pending tests or consults
 - How the communication took place: not face to face, illegible notes, multiple sign outs in one day
 - What the receiver of the information thinks was communicated is often in disagreement with what the sender thinks was communicated

What other industries have taught us (nuclear power industry, airlines, and EMS):

- Techniques including face to face, interactive communication in a safe environment, limited interruptions, providing a written summary, and opportunities for both senders and receivers to introduce topics improve handoffs.
- Relaying information in the same way each time prevents omissions and allows the receiver of the information to anticipate what is next, thereby improving handoffs.
- Contingency plans should be specific as well as the rationale behind those plans so that the receiver understands what could potentially go wrong, what to do about it, and why.
- Read back, used by the receiver to ensure that the sender accurately communicated the sign out, is particularly important because senders over estimate the knowledge that was imparted. Read back also verifies a shared mental model.
- A checklist is used in other industries to avoid omissions.
- Other things to consider include delaying the transfer of responsibility if there is a concern about a particular patient (i.e. patient imminently requiring the PICU), unambiguously transferring responsibility (i.e. nurses know who to call), and assuring time for the receiver to scan through information shortly before or after the handoff.

By remembering a few of the common pitfalls in communication and techniques to improve hand offs, a common source of adverse events can be dissipated. Practicing these techniques and requesting feedback from colleagues and supervisors can improve hand off skills, thereby creating safer care for patients and better use of provider time.

Key References

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 - Patterson ES, Roth EM, Woods DD, Chow R and Gomes JO. Handoff strategies in settings with high consequences for failure: lessons for health care operations. *Intl J Qual Health Care* 2004;16(2):125-132
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