

TRANSITIONS OF CARE: HOSPITAL HANDOFFS



Intern Orientation



Avoiding the Overnight Handover Fumble

Objectives

- After today, you will be able to:
 - Understand the importance of communication around care transitions
 - Identify what patient information should be communicated at handover
 - Know what to include in the “sign-out” sheet
 - Communicate the essential elements of a nightly handover using a standardized format

Outline

- 9:00-9:45 Presentation
 - Define care transitions and handovers
 - Overnight handovers
- 10:00 Break into small groups
- 10:00-11:30 Transitions Workshops

Defining the Problem: Patient Handovers

1. **Transitions of Care**

- Change in patient location, or provider, or both
- ER, ICU, discharge, shift change, service change

2. **Handovers or Handoff**

- The *exchange of information and transfer of responsibility* that occurs during a transition of care

Question

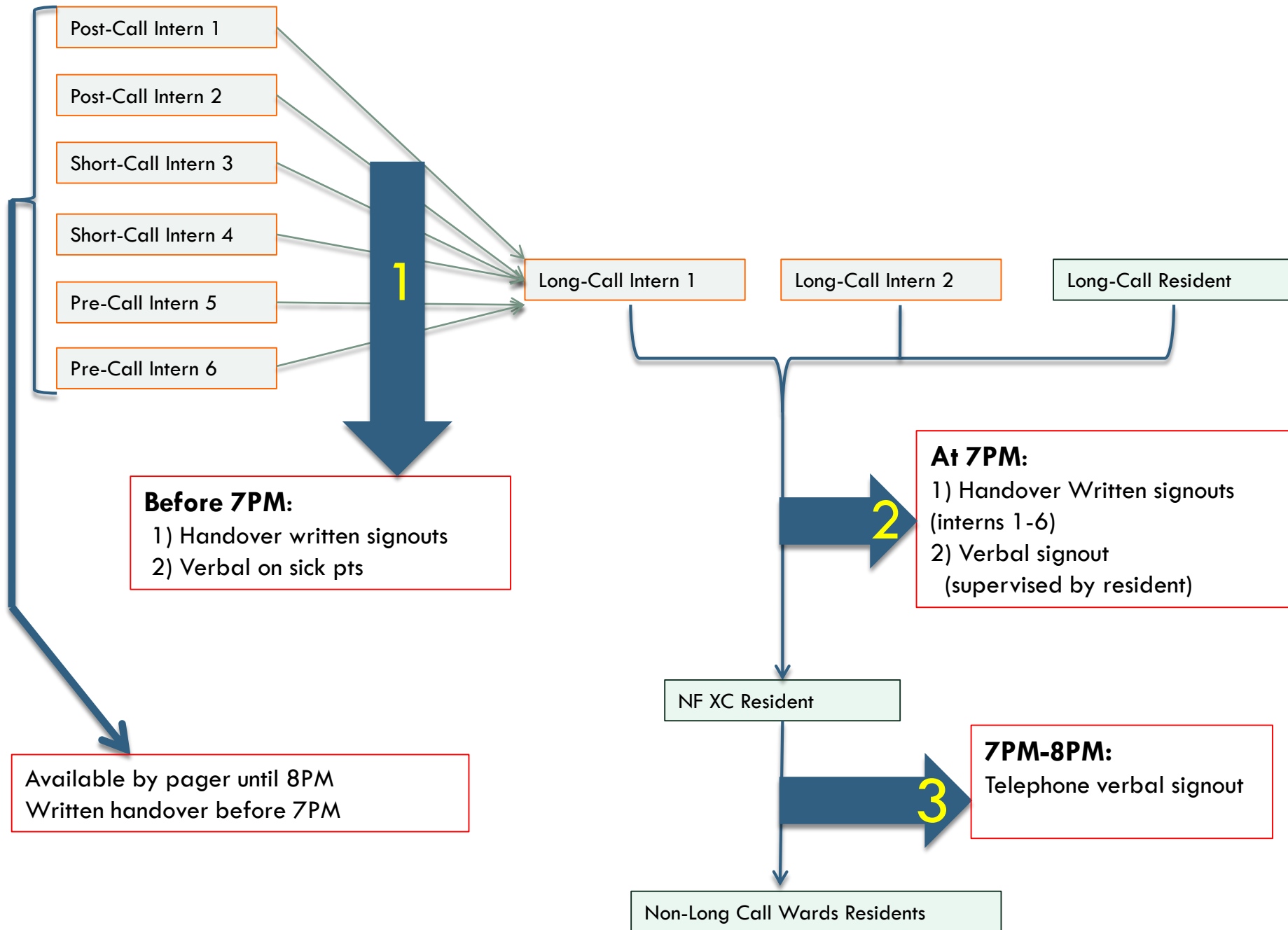
- How many times is an average inpatient transitioned during a 5 day hospitalization?
- A. 5
- B. 10
- C. 15
- D. 25
- E. None of the above

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What the patient experiences

- Average inpatient is transitioned 15 times in a 5 day hospital stay
- Patients can be seen by three different physicians in the first 24 hours of care
- All of this equates to discontinuity and opportunities for medical errors to occur



Frightening Handover Facts

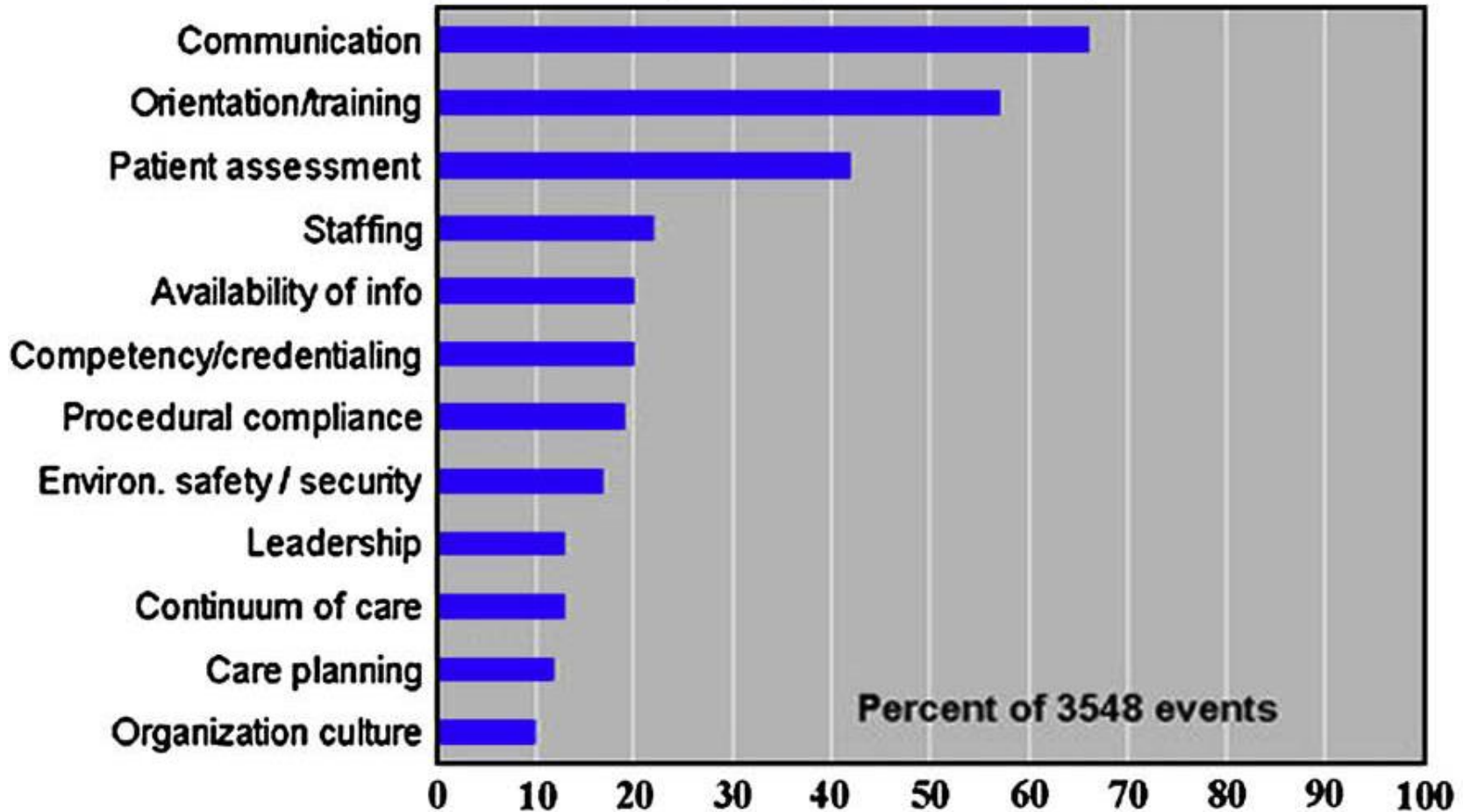
60-80% of sentinel events reported to the Joint Commission had communication errors as a contributing factor

30% of residents report adverse events related to poor handovers; 15% of these were life threatening

\$17 billion is the cost of preventable medical errors



Root Causes of Sentinel Events (All categories; 1995-2005)



The Uncertain Clinician



- A study of the sign-out process noted that “the most important information about a patient was not successfully communicated 60% of the time”
- 73% of pediatrics residents surveyed noted uncertainty regarding care plans due to incomplete verbal hand-offs
- Only 19% of written sign-outs were accurate with respect to patient information and care plans

Worried Patients



- Fletcher et al cited that 28% of patients reported concerns about how often hand offs of care occurred
- In this same study patients' “worries about “fatigue/discontinuity” were significantly associated with trust in and satisfaction with the health care provider

Question

- When extrapolated to all US hospitals approximately how many deaths are attributable to medical error?
 - A. 10,000-40,000
 - B. 40,000-90,000
 - C. 90,000-130,000
 - D. 130,000-170,000
 - E. None of the above

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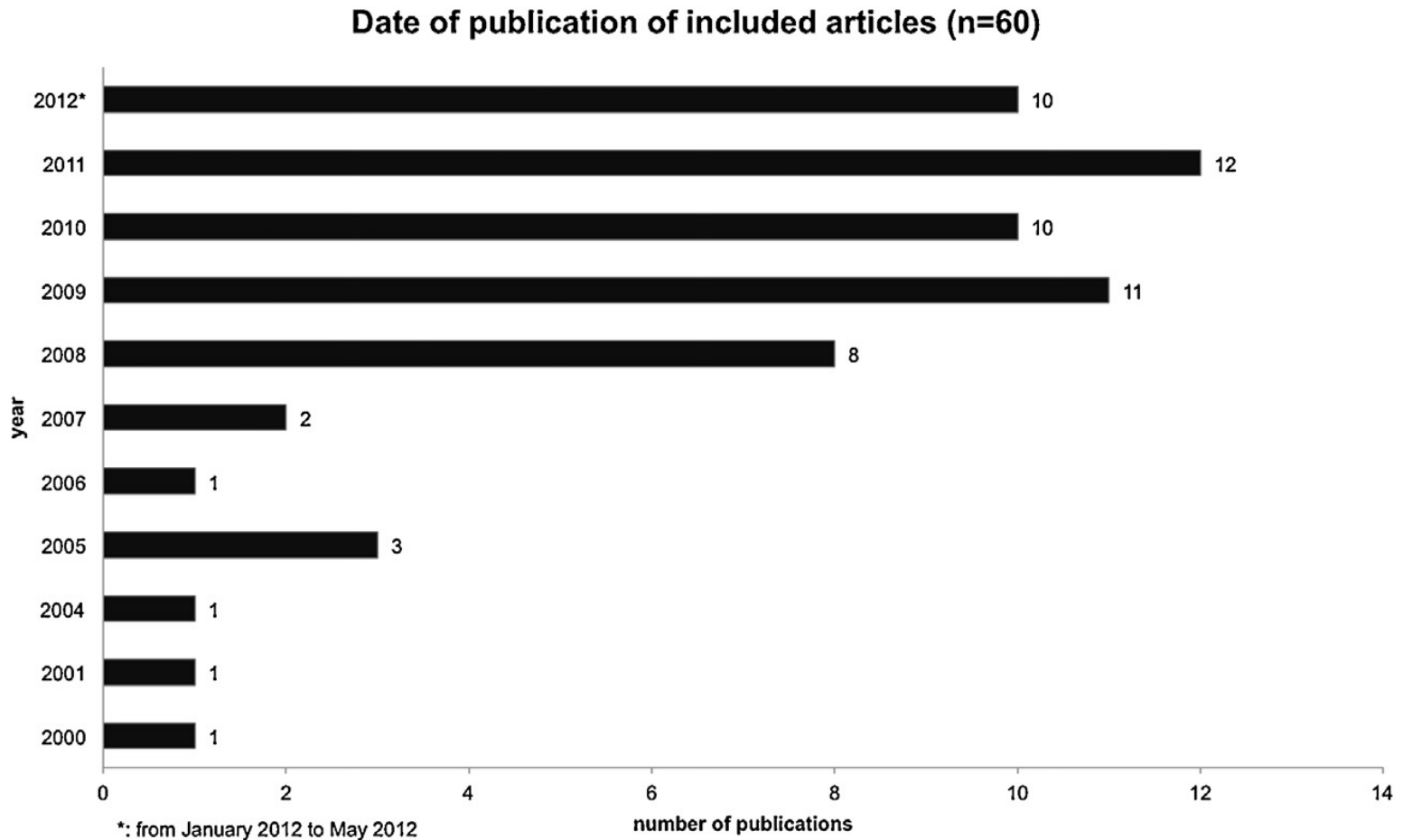
Institute of Medicine

“To Err is Human”



- ~55% of adverse events in hospitalized patients can be attributed to errors.
- When extrapolated to all US hospitals, this represents 44,000 – 98,000 deaths / year caused by medical errors – exceeding deaths by motor vehicle accidents or breast cancer. Medical errors are the 8th leading cause of death.
- Total national costs are estimated between \$17 and \$29 billion (1996 dollars)

Ramping up the Research...



The Goal of the Handover

- Provide information about patient's current condition, care, and treatment
- Anticipate changes in current health status
- Provide rationale for interventions
- “Information presented during hand-off must be accurate in order to meet patient safety goals.”

Optimal Handovers – Society of Hospital Medicine

- Decide on a handoff plan
- Train new users on the plan
- Include verbal exchange of information
- Include a “handoff tool”

Handovers in the Hospital

<http://vimeo.com/12349347>

Barriers to Effective Communication during Patient Handovers

- Interruptions
- Erroneous information becomes “fact”
- Omission of information
- Human Element
- Technology
- Time constraints
- Lack of training

Don't Forget the Big Stuff...

Table 2. Content Omissions During Sign-out With Clinical Consequences

Type of Content Omitted	Definition
Clinical condition of patient	Patient's recent health state, including vital signs, symptoms, physical examination findings, and laboratory values; also stability and trajectory of health state
Recent or scheduled events	Events occurring during hospitalization or scheduled to occur overnight
Task	An assignment to be completed by the covering health care provider overnight
Plan	Instructions on how to complete an assigned task
Rationale	Explanation for an assigned task or plan
Anticipatory guidance	Guidance for events that might reasonably be expected to occur overnight

Components of a Strong Handover

1. **Structured Communication**
 - S₂AIF-IR
 - Both users know what to expect
2. **Dialogue not Monologue**
3. **Close the Loop**



"Hold on -- I'll remember what the knee bone is connected to if I start at the beginning of the song ..."

SAIF-IR

- **S: SICKEST FIRST**
- “This is my sickest patient. This is Mr. C, he is a 70 year-old male located in 5J step-down unit. He was admitted today through the Emergency Room for decompensated heart failure. He has been evaluated by the MICU resident and they are aware of him.”



SAIF-IR

■ S: SUMMARY STATEMENT

■ Basics:

- 1. 1-3 sentences
- 2. Why is he here and what do you think is going on?

on board.



SAIF-IR

A: ACTIVE ISSUES

- “He’s doing a little better, with improved

Basics:

What happened today that I should be aware of?

- “Also, just a heads up that this patient is still a bit confused although that’s improving too. He knows where he is but is not sure why he’s here.”



SAIF-IR



- Basics:
 - 1. Are there any lab or radiology findings that I should be aware of?
 - 2. What do I need to do overnight? If-Then Scenarios!
- If he has chest pain, cardiology needs to be notified as well as the CCU.”

SAIF-IR



- **I: IF-THEN CONTINGENCY PLANNING**
- **F: FOLLOW UP ACTIVITIES**
- “He’s still confused but re-directable and has a sitter in the room. If he gets worse, I’d check a blood gas and another EKG. If those look OK, you can try low-dose Haldol.”
- “He is full code so if his respiratory status worsens and doesn’t improve with BiPAP, he can be intubated.”

SAIF-IR



- **I: INTERACTIVE QUESTIONING**
 - Correct or clarify any information given by the off-going provider

- **R: READ BACKS**
 - Confirm follow-up activity or contingency plans

What about the Sign-Out Receiver?

- ✓ Now is NOT the time to multi-task
- ✓ Active Listening!
- ✓ Clarify tasks
- ✓ Ask questions
- ✓ Close the loop in the morning

To Recap...

- **SAIF-IR**
- **Sickest first, Summary statement**
- **Active issues**
- **If-then contingency planning**
- **Follow up activities**
- **Interactive questioning**
- **Read-back**



Handovers in the Hospital

<https://vimeo.com/99182377>

Final Nightly Handover Thoughts

- ✓ Anticipation is Key!
 - Figure out which patients deserve a more thorough verbal signout
 - Anticipate possible overnight scenarios or recurring problems
- ✓ Avoid general tasks such as “Check CBC”
 - Give specific task and complete with an if-then statement
- ✓ Keep the dialogue open
- ✓ Avoid a multi-tasking scenario

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Transitions of Care Committee



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And Finally...

- Questions?

