INTERDEPARTMENTAL PATIENT HAND-OFF:

WE CAN DO IT BETTER
WHO AM I?

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NO CONFLICTS OF INTEREST
OSCAR WILDE...

“We really have everything in common with America nowadays, except, of course, language.”

THE CANTERVILLE GHOST 1887
SOME QUESTIONS...

• SPECIALTY?
• ARE YOU RESPONSIBLE FOR TEACHING, EITHER STUDENTS OR RESIDENTS?
• IF RESPONSIBLE, DO YOU TEACH THEM HANDOFF TECHNIQUES?
• DO YOU USE A STANDARDIZED SYSTEM FOR HANDOFF?
• HAVE YOU EVER RECEIVED INSTRUCTION IN HANDOFF TECHNIQUES?
• HAVE YOU EVER HAD A PROBLEM ARISE AS A DIRECT RESULT OF A HANDOFF?
IF YOU DON'T KNOW WHERE YOU'RE GOING, YOU'LL PROBABLY NOT WIND UP THERE.
BY THE END OF THIS LECTURE THE PARTICIPANTS CAN…

• IDENTIFY THE CHANGING ROLE OF HAND-OFFS IN HEALTH CARE
• DESCRIBE THE HAZARDS IDENTIFIED IN HAND-OFFS
• CRITIQUE A RANGE OF PROVEN OPTIONS TO USE IN A STANDARDIZED HAND-OFF
• USE THE INFORMATION PRESENTED TO CREATE A STANDARDIZED HAND-OFF OPTION FOR USE IN THEIR INSTITUTION
DEFINITION OF HANDOFF:

- THE TRANSFER OF PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY FOR SOME OR ALL ASPECTS OF CARE FOR A PATIENT, OR GROUP OF PATIENTS, TO ANOTHER PERSON OR PROFESSIONAL GROUP ON A TEMPORARY OR PERMANENT BASIS
DEFINITION OF HANDOFF:

HANDOFF IS A TWO-WAY COMMUNICATION, IDEALLY USING A STANDARDIZED BUT FLEXIBLE COMMUNICATION TOOL.
HANDOFFS...

- I've seen many, many examples of things that go terribly wrong, because the communication of handover information has failed in some way.

- Medical Director, ICU, Australia
STATISTICS...

- Estimated 300 million handoffs per year in the US, 40 million annually in Australia and 100 million in the UK.
- Average patient is handed off 15 times during a five day hospitalization.
- Significant contributor to adverse events in hospital.
- Communication errors in general contribute to as many as 80% of serious medical errors in hospital.
- Handoffs due to a change in inpatient team is related to increased mortality.
ISSUES WITH HANDOFFS:

• HOSPITALS ARE NOT SAFE PLACES!
  • FORTY TIMES MORE LIKELY TO DIE IN AN ACUTE CARE SETTING THAN IN A ROAD CRASH
  • 10% OF PATIENTS IN HOSPITAL SUFFER AT LEAST ONE ADVERSE EVENT
  • OF THOSE ADVERSE EVENTS, 25-40% ARE DIRECTLY RELATED TO POOR HANDOFF

• NO STANDARDIZED PROCESS FOR HANDBOFFS
  • 56.6% OF EDS DO NOT USE A STANDARDIZED HANDBOFF SYSTEM
  • ANOTHER STUDY SHOWED LESS THAN A 20% OF PHYSICIANS USE A STANDARDIZED MODEL

• NO TRAINING IN HANDBOFF TECHNIQUES
  • FEWER THAN 1/3RD OF RESIDENTS REPORT ANY TRAINING IN HANDBOFF TECHNIQUES
Figure 2: Methods for formal assessment of EM resident handoff proficiency

No formal assessment | Assessment by scheduled 1-on-1 discussion | Assessment through written evaluation | Assessment done by senior resident | Other

0.0% | 10.0% | 20.0% | 30.0% | 40.0% | 50.0% | 60.0% | 70.0%
HANDOFF PROBLEMS...

• THE PROBLEM WITH COMMUNICATION... IS THE ILLUSION THAT IT HAS BEEN ACCOMPLISHED.

Democracy is a device that insures we shall be governed no better than we deserve.

- George Bernard Shaw

• GEORGE BERNARD SHAW
PURPOSE OF THE HANDOFF

• TRANSFER OF PATIENT INFORMATION
• TEAM BUILDING: ‘WE ARE ALL IN THIS TOGETHER’
• TEACHING
• GROUP COHESION
THE HANDOFF PROCESS...

• “A FLUID, DYNAMIC EXCHANGE THAT IS SUBJECT TO DISTRACTION, INTERRUPTIONS, FLUCTUATES ON APTITUDE OF AND CONFIDENCE IN OFF-GOING AND ON-COMING CLINICIAN AND IS CONTINGENT ON THE ON-COMING CLINICIAN’S CONFIDENCE IN THE QUALITY AND COMPLETENESS OF THE INFORMATION”

• COOK RI, RENDER M, WOODS DD BMJ 2000; 320:791
PROBLEMS WITH ED HANDOFF...

- 40% of handoffs contained no clinical examination information
- Minimal ‘read back’ checking
- Minimal discussion of home medications
- Patient who have been in the E.D. longest had most incomplete handoffs
  - 42% of hypotensive episodes were not mentioned
  - 74% of hypoxic episodes were not mentioned
A pessimist sees the **difficulty** in every opportunity; an optimist sees the **opportunity** in every difficulty.

- Winston Churchill
INTERDEPARTMENTAL HANDOFF CHALLENGES

• Triggered by the patient's condition
• Interprofessional differences
• Lack of established relationships
• Lack of frequent face-to-face encounters
• Lack of awareness of the accepting unit's status
• Responsibility and control of the patient are often transferred separately

INADEQUATE HANDOFF...

- HANDOFF IS FREQUENTLY:
  - TOO BRIEF
  - PROVIDES INADEQUATE INFORMATION
  - INFORMATION IS INACCURATE
  - UNSTRUCTURED
  - A ‘ONE WAY’ CONVERSATION
RESULTS OF POOR HANDOFF...

• Significant delays in investigations and treatment
• Significant time to ‘catch up’ after a poor handoff
• Poor training in handoff potentiates the problem
• JCAHO and other agencies consider improvements in handoff as a priority
• Significant malpractice costs
PHASES OF A HANDOFF...

- PRE-HANDOFF
- CONTACT TIME
- DIALOGUE
- POST-HANDOFF
<table>
<thead>
<tr>
<th>Conceptual Frame</th>
<th>Primary Function</th>
<th>Risk</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Processing</td>
<td>Transfer data through a noisy communication channel</td>
<td>Missing or inaccurate data set content is transferred and is accurate</td>
<td>Ensure minimum data set content is transferred and is accurate</td>
</tr>
<tr>
<td>Stereotypical Narratives</td>
<td>Categorize by stereotypical narrative and highlight deviations</td>
<td>Inappropriately applying default assumptions</td>
<td>Explicitly label stereotypical narratives and highlight deviations</td>
</tr>
<tr>
<td>Social Interaction</td>
<td>Co-construction of a shared mental model</td>
<td>Failing to support shared sense-making and anticipation</td>
<td>Encourage flexible, adaptive, tailored sharing of perspectives on data</td>
</tr>
<tr>
<td>Resilience</td>
<td>Cross-check assumptions with a fresh perspective</td>
<td>Incorrect framing of problems/risks and solutions/strategies</td>
<td>Create a supportive environment that encourages cross-checking through a question and answer period</td>
</tr>
</tbody>
</table>

CULTURAL CHANGE

• FROM:
  • SHORT IS GOOD

• TO
  • INTERACTIVE IS SAFE

• J PUB HEALTH RES, EDITORIAL
STANDARDIZED TOOLS:

• I  INTRODUCTION
• S  SITUATION
• B  BACKGROUND
• A  ASSESSMENT
• R  RECOMMENDATION
STANDARDIZED TOOLS:

• I IDENTIFY
• S SITUATION
• O OBSERVATIONS
• B BACKGROUND
• A AGREED PLAN
• R READ BACK
STANDARDIZED TOOLS

• S  SITUATION
• B  BACKGROUND
• A  ASSESSMENT
• R  RESPONSIBILITIES AND RISKS
• D  DISCUSSION AND DISPOSITION
• R  READ-BACK AND RECORD

SMITH CJ, BUZALKO RJ ET AL: WEST J EMERG MED; MARCH 1, 2018, 372-379
STANDARDIZED TOOLS

• S  SICK OR DNR
• I  IDENTIFYING DATA
• G  GENERAL ED COURSE
• N  ‘NEWS’
• O  OVERALL HEALTH STATUS
• U  UPCOMING POSSIBILITIES
• T  TASKS TO COMPLETE
• ?  WHAT QUESTIONS DO YOU HAVE?
STANDARDIZED TOOLS

- I  ILLNESS SEVERITY
- P  PATIENT SUMMARY
- A  ACTION LIST
- S  SITUATION AWARENESS AND CONTINGENCY PLANNING
- S  SYNTHESIS BY RECEIVER
FRANKLIN D ROOSEVELT

BE SINCERE;
BE BRIEF;
BE SEATED
WHAT QUESTIONS DO YOU HAVE?
• RCP (UK) ACUTE CARE TOOLKIT 1: HANDOVER
  • [link](http://www.rcplondon.ac.uk/guideline-policy/acute-care-toolkit-1-handover)
• AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
  • [link](http://www.safetyandquality.gov.au)
    • SEARCH FOR ‘CLINICAL HANDOVER’
• INSTITUTE FOR HEALTHCARE IMPROVEMENT*
  • [link](http://www.ihi.org/resources/pages/tools/sbarToolkit.aspx)
• AUSTRALIAN MEDICAL ASSOCIATION; SAFE HANDOVER: SAFE PATIENTS
  • [link](https://ama.com.au/sites/default/files/documents/clinical_handover_0.pdf)
• HANDOVER PROJECT*
  • [link](http://www.handover.cmj.org.pl)
• I-PASS STUDY GROUP*
  • [link](http://www.ipasshandoffstudy.com/home)
    • * REGISTRATION REQUIRED