

We are a company built by doctors, for doctors. We are on a mission to relentlessly defend, protect, and reward doctors who advance the practice of good medicine. When one of our own is attacked we take it personally. Speaking loudly and clearly for tort reform, we are

## Handoffs: A Critical Communication Process

your voice. We are committed to protecting doctors. We loathe litigation, so we work hard to reduce risk. We are devoted to rewarding doctors. We are more than an insurance company. We are The Doctors Company.

WPSC  
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# Handoffs: A Critical Communication Process

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“The greatest problem with communication is the illusion that it has been accomplished.”

—George Bernard Shaw

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# Objectives

- Recall communication techniques to improve the transfer of critical information among providers
- Describe two solutions for practice improvement during handoffs of patient care

# When Information Handoffs Occur

- **Physician coverage**
  - Call coverage
  - Vacation coverage
- **Specialist care**
  - Care transferred to a specialist
  - Care transferred from specialist to primary care

# When Information Handoffs Occur (continued)

- Results and reports
  - Laboratory, radiology, and pathology results to inpatient units
  - Laboratory, radiology, and pathology results to physician practices

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## Patient Care Handoffs—Case #1

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## Case Example: Failed Patient Care Handoff

- 40-year-old female to ED
  - C/o chest pain, shortness of breath, and heart palpitations
- 20-year smoker, history of chronic bronchitis, asthma, allergic rhinitis, mitral valve prolapse, panic disorder
- Chest x-ray: 2 cm nodule in right upper lobe
- Diagnosed with and treated for bronchitis

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## Case Example: Failed Patient Care Handoff (continued)

- Patient was told she has “something in her lung”
- Patient discharged home
- Follow-up with primary care three days later
- Primary care physician did not have privileges at that hospital; did not receive copies of medical record or CXR report

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## Case Example: Failed Patient Care Handoff (continued)

- Neither ED physician nor radiologist called primary care physician regarding nodule in lung
- Patient did not mention it
- Patient seen three additional times over the next six months for various complaints

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## Case Example: Failed Patient Care Handoff (continued)

- Patient then seen by primary care for three-week history of pleuritic pain and cough
- Repeat CXR showed 3 cm lesion in right upper lobe
- Non-small cell cancer, stage 3B
- Patient treated but expired 10 months later

# Patient Safety Lessons

- **Communication of abnormal findings**
  - Communication between radiologist and ED physician
  - Communication between ED physician and primary care
  - Communication with patient
- **Documentation of communications**

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## Patient Care Handoffs—Case #2

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# Case Example: Failed Information Transfer Call Coverage

- 54-year-old male: c/o leg weakness
- History
  - Cirrhosis of the liver
  - Hepatitis C
  - Alcoholism
  - Hepatic encephalopathy
  - Grade III esophageal varices
- Admitted to hospital with massive edema in lower extremities and ascites
  - H/H =10.2/31.5

## Case Example: Failed Information Transfer Call Coverage (continued)

- **Attending (internal medicine) had good relationship with family**
  - Practice included three physicians
- **Weekend**
  - Attending off
  - Partner #1 made hospital rounds
- **Patient had coffee-ground emesis**
  - NG tube ordered by partner #1
  - Nurse unable to place NG tube
  - Family requested nurse contact on-call physician, partner #2

# Case Example: Failed Information Transfer Call Coverage (continued)

- Partner #2 contacted
  - Told nurse to contact partner #1 who made rounds
- Nurse contacted partner #1
  - Partner #1: “I’m not on call. Speak with attending on Monday.”
- Family angry

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## Case Example: Failed Information Transfer Call Coverage (continued)

- Monday: Patient examined by attending
  - Poor condition
  - Decreased level of consciousness
  - Agonal respirations
  - DNR order obtained
- Patient expired two hours later
- Allegation: Failure to diagnose and treat GI bleed

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## Call Coverage Communication: Patient Safety Lessons

- Covering physicians agree on how rounds and calls will be handled
- Use a standard format for physician-to-physician communication
- Information to include:
  - Patient's status
  - Medications
  - Treatment plans
  - Advance directives
  - Any significant status change

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## Call Coverage Communication: Patient Safety Lessons (continued)

- Brief covering physicians about:
  - Any anticipated patient care problems
  - Hospitalized patients
  - Acutely ill patients
- Provide covering physicians with access to patient records

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## Communication of Test Results

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# Failed Communication of Test Results Leads to Diagnosis-Related Errors

- Association for Healthcare Research and Quality (AHRQ)
  - “Diagnostic Error in Medicine: Analysis of 583 Physician-Reported Errors”<sup>1</sup>
  - Survey responses from 310 clinicians; 22 institutions
  - Reported 583 incidents of missed or delayed diagnoses

<sup>1</sup>*Archives of Internal Medicine*, Nov. 9 (2009).

# Failed Communication of Test Results Leads to Diagnosis-Related Errors (continued)

- Errors occurred most frequently in testing phase
  - Failure to order, report, and follow-up laboratory results  
44 percent
- Errors in ordering, reporting, and follow-up on test results frequently leads to diagnosis-related errors
  - Communication of test results to other providers
  - Communication of test results to the patient

# Informing Patients of Abnormal Results

- **DANGEROUS** assumption:
  - “No news is good news”
- Leads to patients not being informed of abnormal results

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## Patient Care Handoffs—Case #3

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## Case Example: Failure to Inform Patient of Abnormal Result

- 43-year-old female, mass in left breast on mammogram in 2004
  - Mass monitored by primary care physician for two years
- 2006 mass biopsy; benign hyperplasia
- January 2008 patient felt increase in size
  - Repeat mammogram ordered by primary care
  - Told surgeon would be notified of results
  - Told she would be contacted by surgeon if there was a concern

## Case Example: Failure to Inform Patient of Abnormal Result (continued)

- August 2008 patient had appointment with surgeon
  - Large mass on January mammogram, “cannot rule out new hyperplastic changes”
  - Addendum: recommended repeat biopsy
- Biopsy: malignant
- Modified radical mastectomy, radiation, chemotherapy
- November 2008 metastases to ribs and lungs

# Best Practices: Informing Patients of Test and Diagnostic Results

- **Five simple processes**

- 1) All test results routed to responsible physician
- 2) Physician signs off on all results
  - Initials, date, and time
- 3) Practice informs patient of all results
  - Normal and abnormal
  - Can be in general terms

# Best Practices: Informing Patients of Test and Diagnostic Results (continued)

- **Five simple processes** (continued)
  - 4) Practice documents patient has been informed
  - 5) Patients told to call after a certain time interval if they have not been notified

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## 2010 Joint Commission National Patient Safety Goals (NPSG)

- Goal 2: Improve the effectiveness of communication among caregivers
  - NPSG.02.03.01
  - Report **critical results** of tests and diagnostic procedures on a timely basis

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## Communication of Radiology Results

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## Patient Care Handoffs—Case #4

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## Case Example: Failure to Communicate Radiology Results

- 56-year-old female; wheelchair dependent
  - Childhood polio
- Fell from wheelchair
- To ED with c/o bilateral arm pain
- ED physician read x-rays as normal
  - Pt. discharged home with diagnosis arm strain/sprain

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## Case Example: Failure to Communicate Radiology Results (continued)

- Next day radiologist read x-ray as fractured left supracondylar humerus
  - Radiologist did not call ED
  - Patient was not notified

## Case Example: Failure to Communicate Radiology Results (continued)

- Five days later patient went to primary care physician c/o left arm pain
- PCP reviewed ED x-ray
  - Identified non-displaced fracture of humerus
- Repeated x-ray
  - Humerus now displaced
- Surgery required
  - Patient depended on left arm for transfers

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## Patient Safety Points: Radiology Results

- Over-reads of ED x-rays by radiologist
- Communication of radiologist findings
  - Communication to ED physician
  - Communication to primary care
  - Communication to patient

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## Communication Techniques

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# Read Back/Repeat Back

- For verbal or telephone orders
- For reporting critical results
- Method:
  - The individual receiving the information
    - Writes down the complete order or test result, or
    - Enters it into the computer
  - The individual receiving the information
    - **Reads back** what has been written
  - The individual who gave the order
    - Verifies the correctness

# Standardized Abbreviations

- Standardized abbreviations, acronyms, symbols, and dose designations
- Do Not Use list
  - Do not use in medication orders
  - Do not use in medication-related documentation
  - Do not use on pre-printed forms
  - Do not use in handoff communications to other providers

# “Do Not Use” Abbreviations

- List available on the Joint Commission Web site<sup>1</sup>
- Electronic medical records or computerized physician order entry (CPOE) systems
  - Dangerous abbreviations, acronyms, symbols, and dose designations should be eliminated from the software

<sup>1</sup>[www.jointcommission.org](http://www.jointcommission.org)

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# SBAR+R Acronym

S- Situation

B- Background

A- Assessment

R- Recommendation

R- Response / Repeat Back

Source: [www.ihi.org](http://www.ihi.org)

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# SBAR+R Content

- **Situation:**
  - What is happening at the present time?
- **Background:**
  - What are the circumstances leading up to this situation?
- **Assessment:**
  - What is the problem?
- **Recommendation:**
  - What should be done to correct the problem?
- **Repeat back:**
  - Repeat back the plan of care

# SBAR+R Purpose

- Purpose
  - Close the gap between physician and nurse communication
  - Augment communication between all health care providers and staff
  - Allow both parties to have common expectations related to what is communicated

# SBAR+R Example

- **S** = “Dr. Smith, this is Mary at General Hospital calling regarding Mr. Cook in 212. His temperature is up to 103.5.”
- **B** = “He is POD #2 S/P right knee replacement.”
- **A** = “The wound is red; pulse is up to 115 from baseline of 80; his pain level has increased to 9/10 despite increasing his Vicodin dosing to ii tabs Q4.”
  - Specific numerical values are given in the assessment
- **R** = “I would like you to come see him. When can I expect you?”
  - Asking for a specific time frame
- **R** = “I will be there in 15 minutes, I am in the PACU.”

# “I Pass the Baton”

- **I** = Introduction
- **P** = Patient
- **A** = Assessment
- **S** = Situation
- **S** = Safety concerns
  
- **B** = Background
- **A** = Actions
- **T** = Timing
- **O** = Ownership
- **N** = Next

Source: [www.who.int/patientsafety/education/curriculum/](http://www.who.int/patientsafety/education/curriculum/)

# Handoff Errors = Preventable Harm

- Handoffs may contain information that is
  - Misleading
  - Inaccurate
  - Incomplete
- Amenable to process improvement

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# Summary: Safer Handoffs

## Patient Safety Approaches

- Redundancies
  - Checklists
  - Read-backs
  - Include the patient
- Standardization
  - Procedures
  - Information sharing

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## **Our Mission Is to Advance, Protect, and Reward the Practice of Good Medicine.**

For additional information, please contact  
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