NC QC PSO & CHPSO Present

Safer Handoffs – Part 2

February 28, 2012

The
North Carolina
Quality Center PSO

CHPSO

Objectives

- Identify benefits of using a standardized form
- Recognize the role of human factors in handoff quality

Strategies for Standardizing a Successful Hand-off: Meeting the Joint Commission Standard

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Today's Call

- Present a Model for developing a standard protocol for hand-offs for your discipline
- Review what is currently known about hand-offs in medicine and other industries
- Discuss data from our institution
- Review lessons learned and answer questions

By The End of Today's Call

- You will have learned the tools necessary to develop:
  - A standard process
  - Checklist of necessary content
  - Implementation strategies
  - A plan for monitoring and evaluation

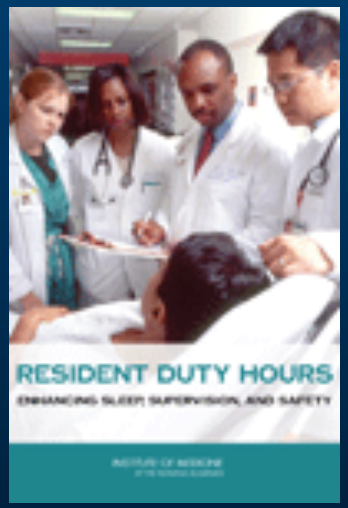
Calls to Improve Handover

The Joint Commission , 2006

National Patient Safety Goal: a standardized approach to hand-off communications & provide an opportunity for staff to ask and respond to questions about a patient's care

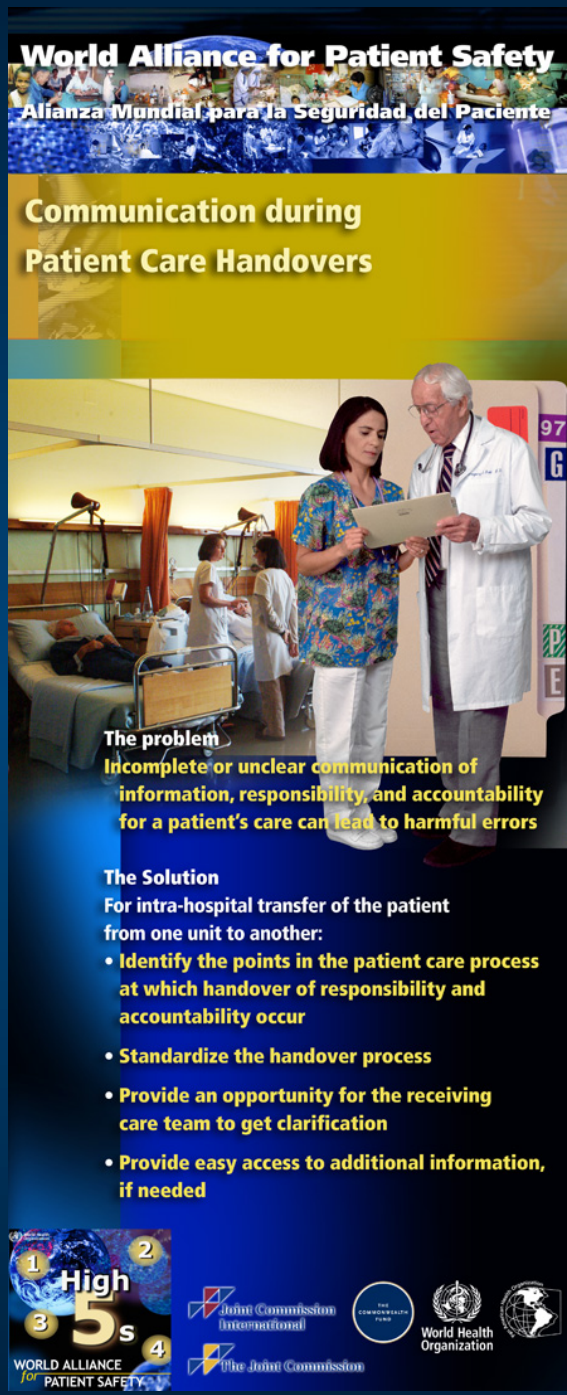
World Health Organization, 2006

Prevention of handover errors part of "high fives" patient safety solutions



IOM 2008/ACGME 2011

Teaching programs "should train residents in how to hand over their patients using effective communications"

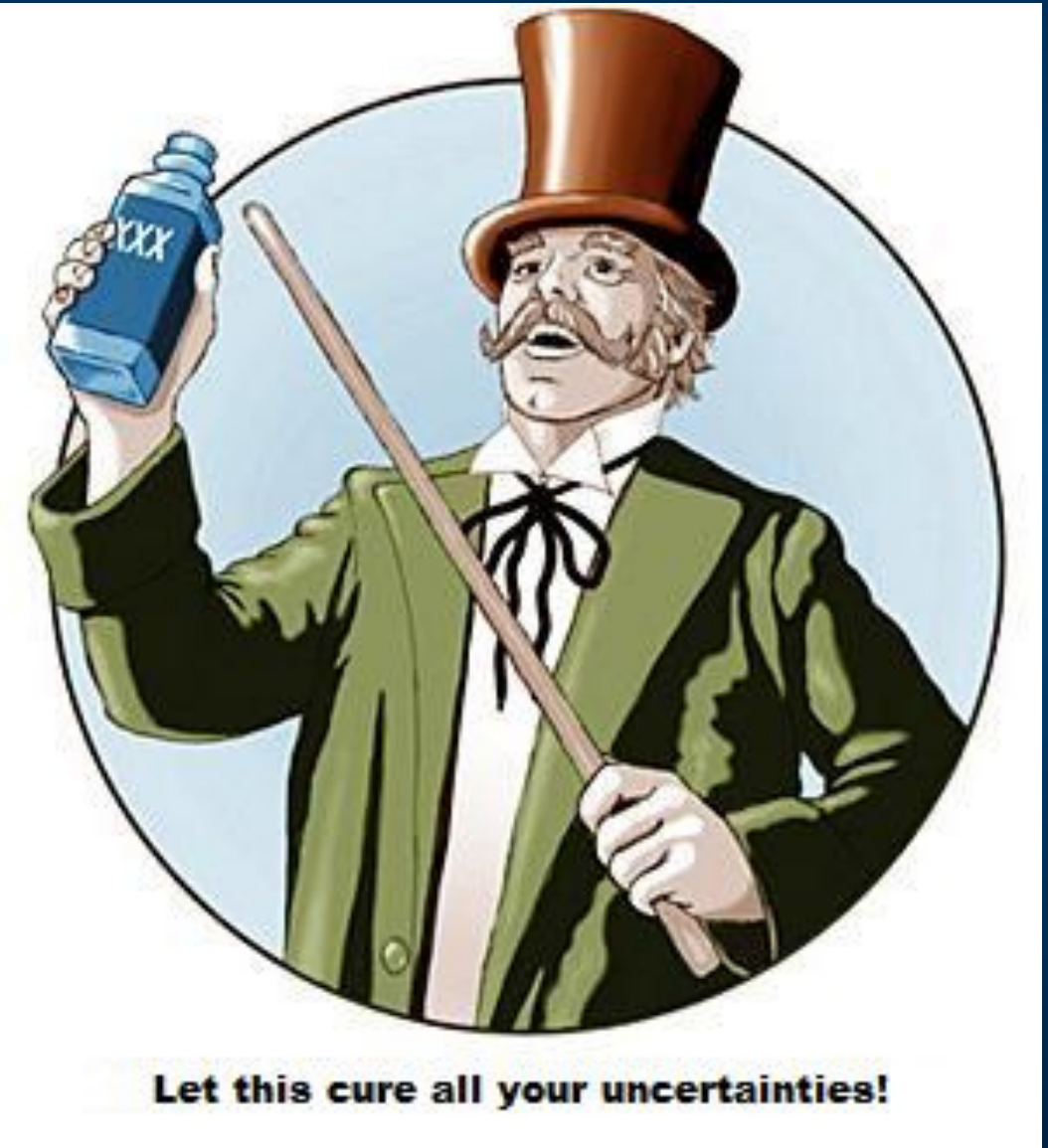


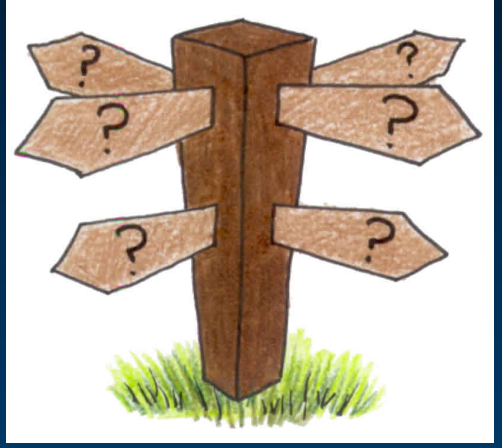
Components of Handoffs

- Verbal Communication
  - In person or over phone
- Written communication
  - Signout
- Transfer of Professional Responsibility

In Search of the Cure All

- Many in search of the one size fits all solution
  - SBAR?
  - Checklist?
  - Technology solution?
  - Other?
- Challenge given the different needs of programs and types of patients





Where to Begin?

Select a handoff to improve

Apply a 4 step method to standardize

Risk Stratifying Handoffs

1. Is the patient physically moving?
2. Is the patient critical or unstable?
3. Is the hand-off temporary or permanent?
4. *Is this the first time the receiver is hearing about a patient?*

If yes to any question, inherent increase in safety risk

Admission (EMS-ED or ED-floor/ICU)
A floor patient going for urgent surgery OR to PACU

UHC® University HealthSystem Consortium

Standardizing Handoffs in 4 Steps

- Principles
  - Protocol will be discipline specific
  - Standardization is key for both process and content
    - PROCESS
      - Create a process map
    - CONTENT
      - Create a standard check-list
    - IMPLEMENTATION
      - Buy-in of staff
    - MONITORING
      - Identify and resolve barriers

Joint Commission™ Journal on Quality and Patient Safety

National Patient Safety Goals

A Model for Building a Standardized Hand-off Protocol

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In July 2003, the Accreditation Council for Graduate Medical Education (ACGME) set limits for resident duty hours.[1] Although the main driving force was to reduce sleep deprivation and improve patient safety, one unintended consequence was the increase in the number of handoffs during patient care. The discontinuity of care that thereby results has the potential to undermine the beneficial effects of work hour limitations.[2] The safety of the hand-off process has been called into question by a number of different sources and studies which suggest that handoffs are often characterized by communication failures and environmental barriers.[3,4]

The handoff is also the subject of a Joint Commission on Accreditation of Healthcare Organizations National Patient Safety Goal, which went into effect January 1, 2006. Written as a new requirement of Goal 2, Improve the Effectiveness of Communication Among Caregivers, this addition requires hospitals to implement a standardized approach to hand-off communications and provide an opportunity for staff to ask and respond to questions about a patient's care[6,7] (Sidebar 1, page 647). Although the standard applies to all handoffs that occur between all personnel within all health care settings, the focus of this article is on the handoffs between residency trainees at academic teaching hospitals. Because medical trainees receive little to no formal training or education in communication during handoffs, there is an inherent opportunity to influence the practice of

Article-at-a-Glance

Background: The Joint Commission has made a "standardized approach to hand-off communications" a National Patient Safety Goal.

Method: An interactive 90-minute workshop (hand-off clinic) was developed in 2005 to (1) develop a standardized process for the handoff, (2) create a checklist of critical patient content, and (3) plan for dissemination and training.

Conclusion: To date, 7 of 10 residency programs have participated. Analysis of these protocols demonstrated that the hand-off process is highly variable and discipline-specific. Although all disciplines required a verbal handoff, because of competing demands, verbal communication did not always occur. In some cases, the transfer of professional responsibility was separated in time and space from the transfer of information. For example, in two cases, patient tasks were assigned to other team members to facilitate timely departure of a postcall resident (to meet resident duty-hour restrictions), but results were not formally communicated to anyone. The hand-off clinic facilitated the incorporation of "closed-loop" communication by requiring that follow-up on these tasks be conveyed to the on-call resident.

Discussion: This model for design and implementation can be applied to other health care settings.

Understanding Hand-offs as a Process

"The first step is to draw a flow diagram. Then everyone understands what his job is. If people do not see the process, they cannot improve it."

W.E. Deming, 1993

Process Mapping – Brief Overview

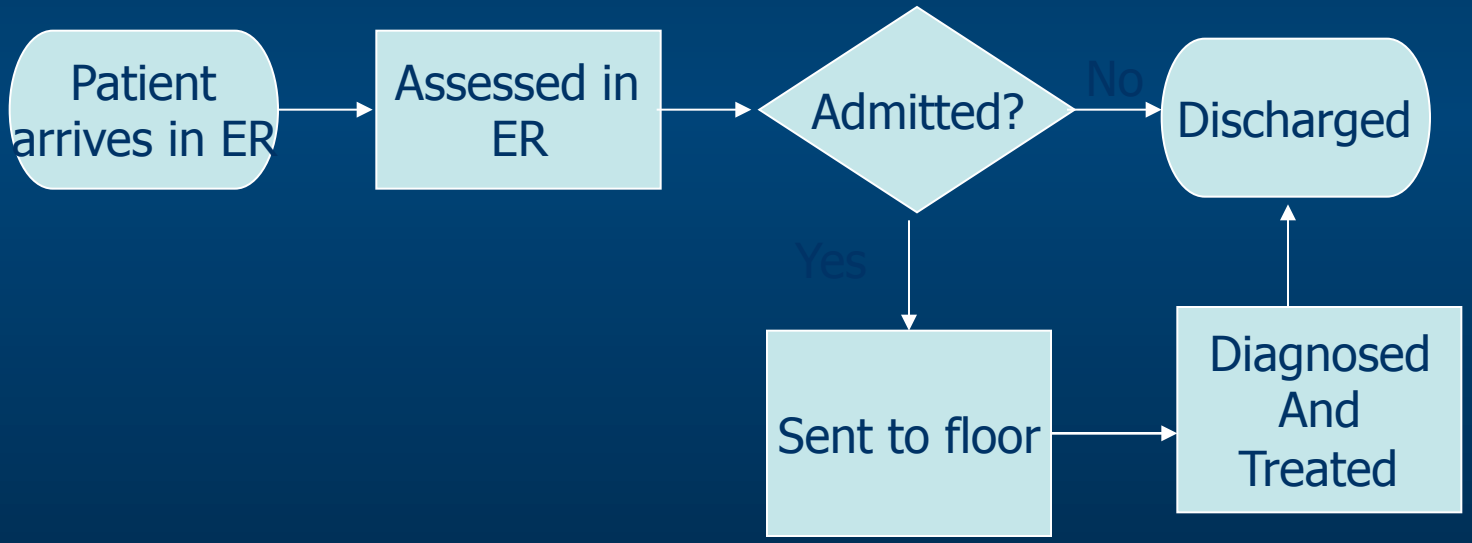
- A process map or flowchart is a picture of the sequence of steps in a process
- Useful for
  - Planning a project
  - Describing a process
  - Documenting a standard way for doing a job
  - Building consensus about the process (correct misunderstandings about the process)

Process Mapping

- Ovals are beginnings and endings 
- Boxes are steps or activities 
- Diamonds are questions 
- Arrows show sequence and chronology 

Process Mapping

- Can be “high-level” to get an overview of the process



Process Mapping

- Can also be very detailed and “drilled down” to show the details and roles
- Detailed process maps are especially helpful to standardize and improve processes
- For use as an improvement tool, it is important to map the current process, not the desired process

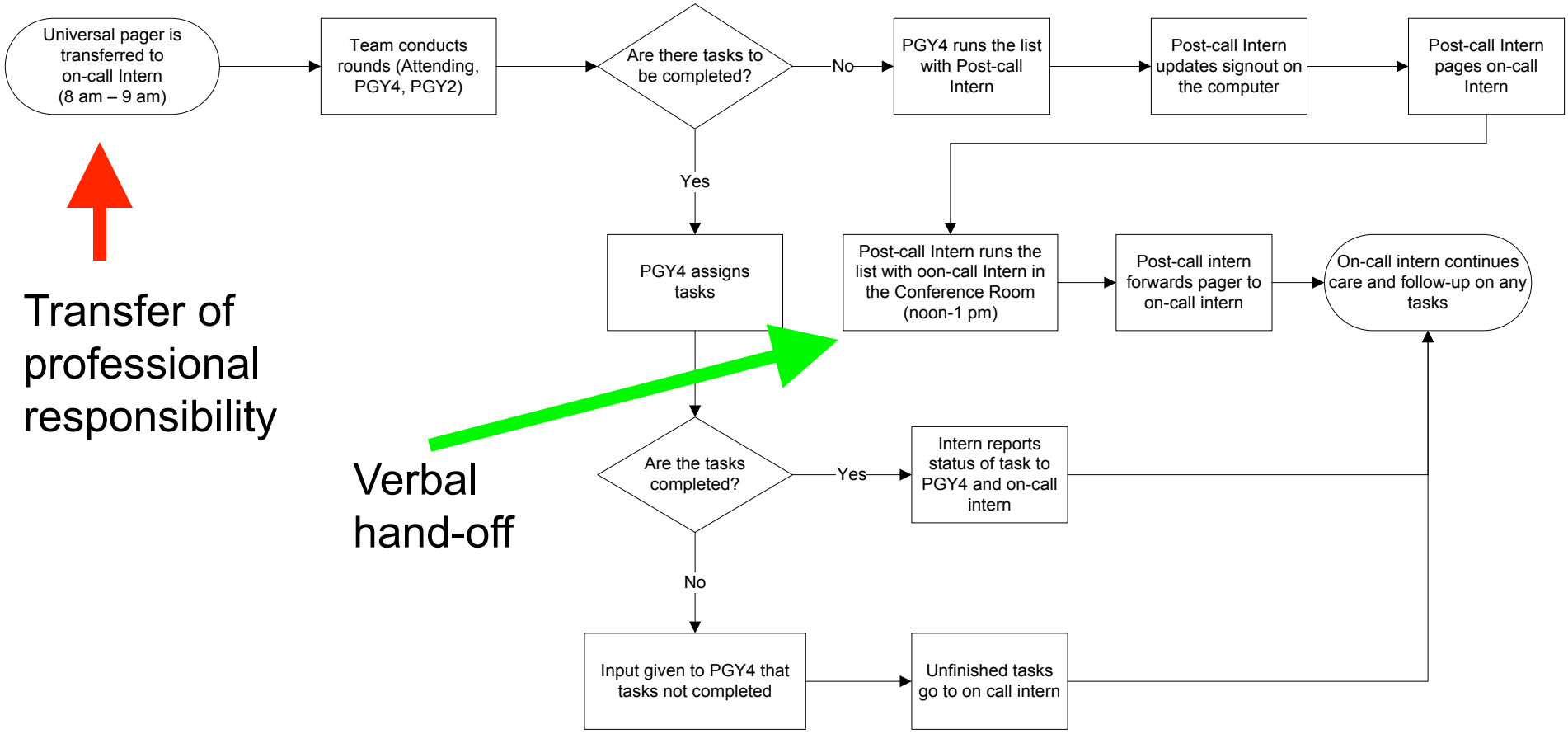
Analyzing Process Maps

- Review of process maps
  - What is the goal of the process?
  - Does the process work as it should?
  - Are there obvious redundancies or complexities?
  - How different is the current process (the one you drew) from the ideal process?

Pre-handoff	Arrival	Dialogue	Post-handoff
Sender organizes & updates handoff information	Stop patient care tasks to conduct handoff	Specific verbal exchange between sender and receiver (could be in person or over phone)	Receiver integrates new information and assumes care of patient(s)
• Lack of time, poor time management, fatigue, or work prevent updating • Lack of clinical judgment to construct proper handoff • Vague language	•No set location or time •Not able to contact sender or receiver •Competing obligations (work or personal) •Handoff not a priority over tasks	***Sender could*** •Provide disorganized info •Use vague or unclear language •Fail to provide clinical impression (what is wrong), anticipatory guidance (if/then), plan (to do), & rationale (why) ***Receiver could*** •Not listen (distractions) •Misunderstand •Not clarify (ask questions)	•Forget key tasks or information •Not document actions taken •Act on plan without taking new arriving information into account •Not invest in the care of patient (lack of professional responsibility)

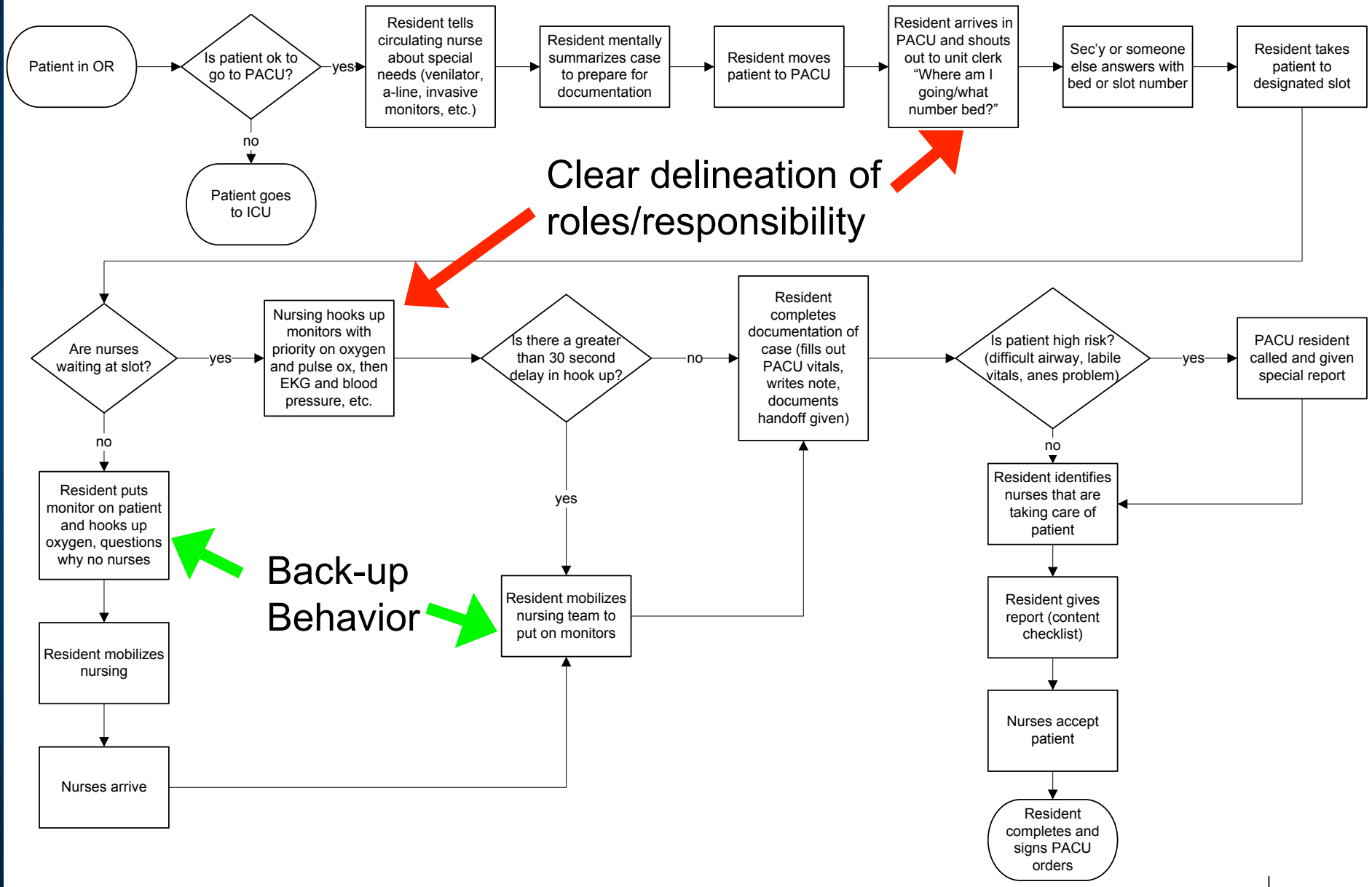
Sign-out Process for Neurology

March 17, 2006



Process for Anesthesia – Resident to PACU Nurse Handoff

April 12, 2006



Step 2: Standardize Content But, first gather Information

- Engage front-line staff
  - What are the elements of the ideal handoff?

- Methods
  - Direct observation
  - Interview (post shift)
  - Survey

Interview

- One example, from our institution
  - To characterize communication failures during the hand-off of hospitalized patients that may lead to patient harm
  - To solicit suggestions for improvement for both written and verbal sign-out

Arora, Johnson, et al. Quality and Safety in Healthcare, 2005.

Critical Incident Interviews

Question designed to elicit information about adverse events and near misses
Was there anything bad that happened or almost happened last night because the (VERBAL/WRITTEN) sign-out wasn't as good as it could have been?
Question designed to elicit information about worst event experienced in past year
Can you tell me the single most severe adverse event that you were involved in over that last year that resulted from a deficient sign-out?
Question designed to elicit information about ideas for improvement
Regardless of whether anything went wrong or almost went wrong, and thinking about what should be included in a sign-out, is there anything about the (VERBAL/WRITTEN) sign-out that you received that you think should have been better?

Arora, Johnson, et al. Quality and Safety in Healthcare, 2005.

Adverse Events/Near Misses due to Poor Sign-out in Preceding Shift

Category (n)	Sub-category (n)	Representative Incident (n=25)*
Content Omissions (22)	Medications or Therapies (11)	*There was a patient who had their heparin drip turned off and it was not mentioned to me that it was turned off.*
	Tests or Consults (10)	*There was a consult that was pending that was not listed and then ID [infectious disease] and pulmonary called with recommendations and there was no note that these recommendations were coming or what I should do with them.*
	Active Medical Problems (9)	*There was a patient that had hematuria and it was not indicated on the sign-out. They had ordered CBI [continuous bladder irrigation] and I had no idea.*

Taxonomy of Sign-out Quality

POOR SIGN-OUT

Content Omissions
- Medications or Therapies
- Tests or Consults
- Medical Problems
  - Active
  - Anticipated
- Baseline status
- Code status
- Rationale of primary team

Failure-Prone Communication Processes
- Lack of Face-to-Face Communication
- Double Sign-out ("Night Float")
- Illegible or Unclear Handwriting

EFFECTIVE SIGN-OUT

Written Sign-out
- Patient Content
  - Code status
  - Anticipated problems
  - Active Problems
  - Baseline Exam
  - Pending Test or Consults
- Overall Features
  - Legible
  - Relevant
  - Accurate
  - Up-to-date

Verbal Sign-out
- Face to Face
- Anticipate
- Pertinent
- Thorough

Determine the Standard Content ("ANTICipate")

- Create a standard checklist
- Customize it to your discipline
  - Use institutional/ professional jargon
- Prevent content omissions
  - Can be used to evaluate the quality of hand-offs
- Use it as a teaching tool
  - Particularly helpful for new staff

✓ **A**dministrative Data
- □ Patient name, age, gender
- □ Medical record number
- □ Room number
- □ Admission date
- □ Primary inpatient medical team, primary care physician
- □ Family contact information

✓ **N**ew Information (Clinical Update)
- □ Chief complaint, brief HPI, and diagnosis (or differential diagnosis)
- □ Updated list of medications with doses, updated allergies
- □ Updated, brief assessment by system/problem, with dates
- □ Current "baseline" status (e.g., mental status, cardiopulmonary, vital signs, especially if abnormal but stable)
- □ Recent procedures and significant events

✓ **T**asks (What needs to be done)
- □ Specific, using "if-then" statements
- □ Prepare cross-coverage (e.g., patient consent for blood transfusion)
- □ Warn of incoming information (e.g., study results, consultant recommendations and what action, if any, needs to be taken that night

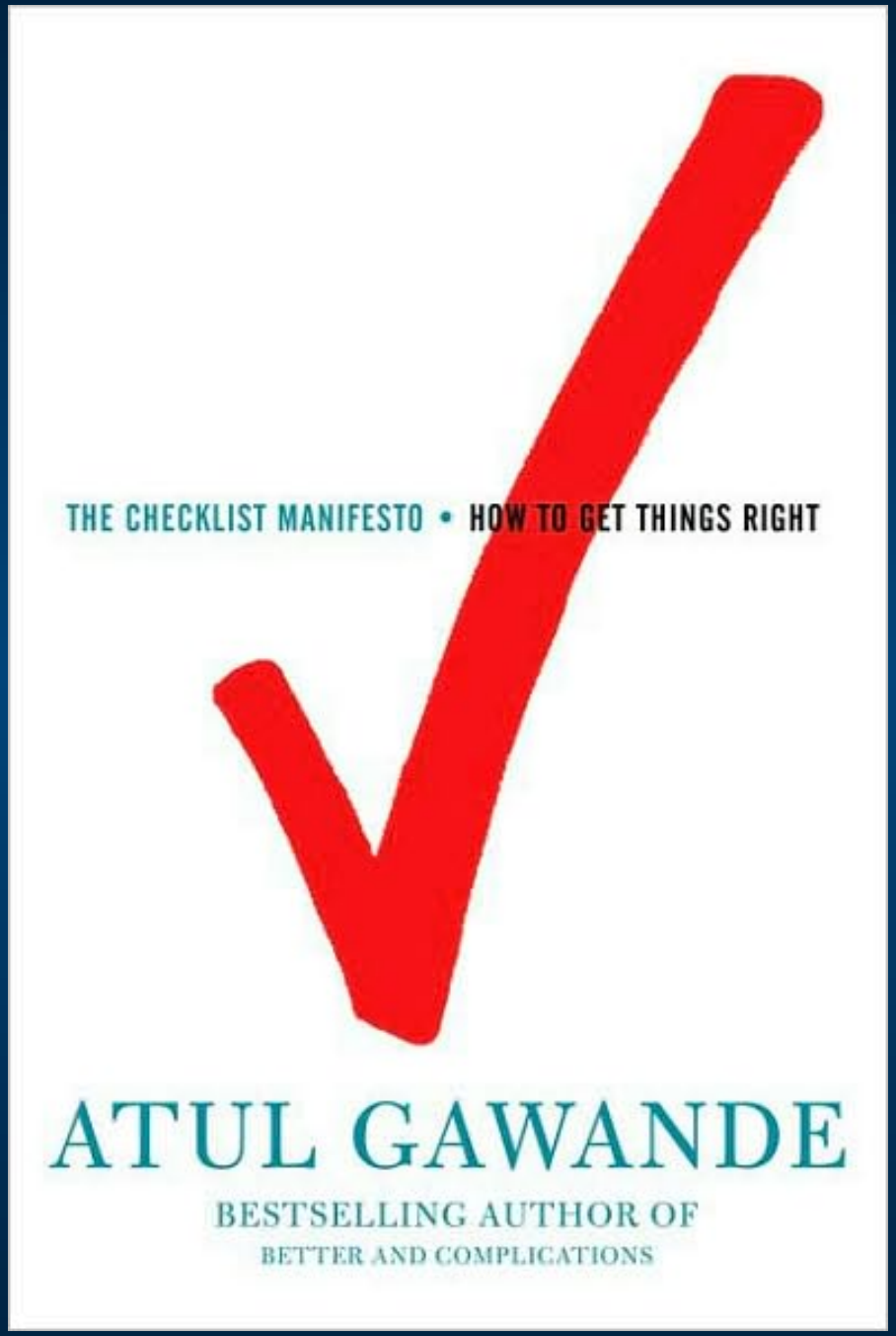
✓ **I**llness
- □ Is the patient sick?

✓ **C**ontingency Planning / **C**ode Status
- □ What may go wrong and what to do about it
- □ What has or hasn't worked before (e.g., responds to 40mg IV furosemide)
- □ Difficult family or psychosocial situations
- □ Code status, especially recent changes or family discussions

- ✓ **P**sychiatric history
  - □ One liner with hospital presentation "21 yo AAF with hx depression and previous SA presented now with SI and the plan of cutting wrists."
  - □ Hospital course including what was tried (i..e trial of Seroquel, etc.) and worked (i.e. Geodon 20mg IM worked) and progress to date (i.e. "no restraints since 3/6")
  - □ Systems-based list of current problems (psychiatric and medical)
- ✓ **S**pecial instructions
  - □ Precautions: Seizure, Fall Suicide, etc.
  - □ Roomate ("Can have roommate" or "needs private room")
  - □ Restraint use "Please do NOT allow restraints unless pt is violent & undirectable"
  - □ Primary team rationale (i.e. "Avoiding high-EPS neuroleptics")
  - □ Patient nuance (i.e. "Never tell her she's doing better. This is not therapeutic for her.")
- ✓ "For **Y**ou, For me "
  - □ To do list for cross-cover (i.e. "check x level and adjust x" or "NTD")
  - □ Continuing reminder for hospital stay in the "For me"
- ✓ **C**ourt/Legal Issues
  - □ Decision-making capacity ("Voluntary" or "Involuntary")
  - □ Status of certificate (i.e. "Awaiting judge's decision at trial for involuntary")
  - □ Name and contact of decision maker if patient is not able to make decisions
  - □ When to notify decision maker (i.e. "NOTIFY OF ALL MED CHANGES")
- ✓ **H**ousing and Social Issues
  - □ Nursing home placement or other dispo (i..e "home")
  - □ Needs to get check
- ✓ **I**f/Then
  - □ Frequent issues to be expected with a plan to resolve using IF/then format (i.e. "if insomnia, try Prosom" or "if agitated, try Haldol" etc.) especially for sleeping problems
  - □ ALSO What does NOT WORK (i.e. Avoid BNZ, restraints, etc)
- ✓ **A**dministrative data/Allergies
  - □ Patient name, Medical record number
  - □ Room number
  - □ Admission date
  - □ Outpatient psychiatrist
  - □ Family contact information
  - □ Allergies (medication, latex, contrast, food, etc.)
- ✓ **T**herapeutics
  - □ Medications (updated list with doses, start date, any recent adjustments)
  - □ Include PRN's and what works
  - □ ECT Orders
- ✓ **R**esults of Pertinent Labs & Radiolog**y**
  - □ Labs (i.e. Drug levels, CK levels)
  - □ Radiology findings and test date

Psychiatry check-list

- Routine fields
  - Admin data
  - Therapeutics
  - To-do
  - If/then
- Discipline-specific fields
  - Housing
  - Court/legal issues
  - Special instructions etc.



Is the checklist the holy grail?

Caution for ‘checklists’

- Check the box mentality
  - Complete the form but don’t improve care
    - Checkbox for “I contacted the PCP”
- Forms don’t fill out themselves
  - Training and frontline buy-in
- One size fits all doesn’t always work
  - Customization often needed (i.e. SBAR)
- Sustaining behavior change difficult
  - Audits to ensure continued use
  - Engage frontline staff to customize

Case of SBAR

- Originated in Navy to communicate critical situations
- Adapted for nurse to physician communication
- Became most commonly described handoff mneumonic

Misuse of SBAR

- Using “SBAR” as a verb
  - “I’ m SBARing”
- Failing to customize and specify the precise elements in each category
  - Likely that situation for a L&D unit differs from a geriatrics unit
- Assumption that using SBAR checklist will result in comprehensive information transfer

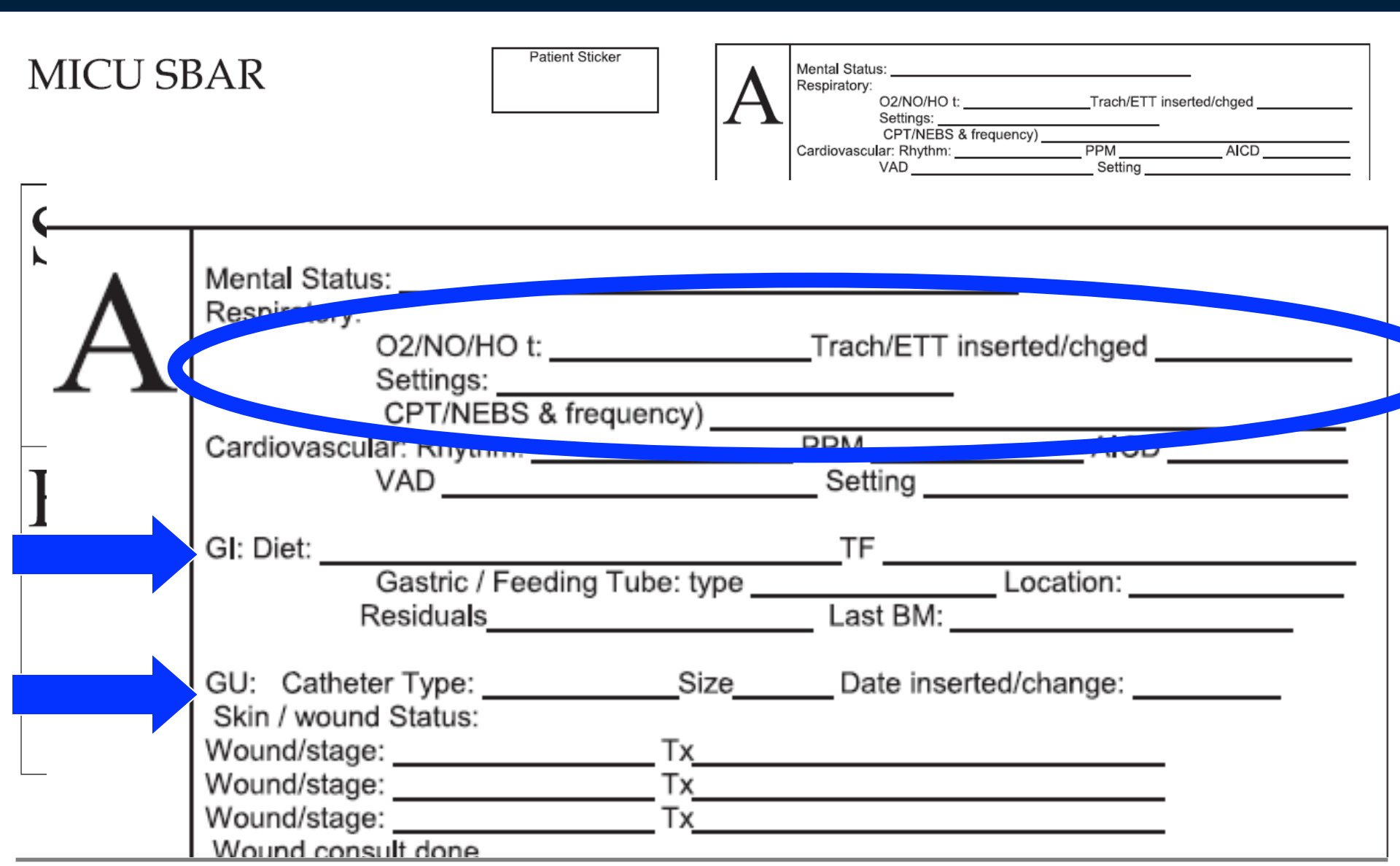


Figure 6. *The MICU Situation, Background, Assessment, and Recommendation (SBAR) focused on respiratory issues and intravenous (IV) access for their patients, who are likely to be intubated and on vasopressors. ETT, endotracheal tube; AICD, automatic implantable cardioverter defibrillator; VAD, ventricular assist device; BM, bowel movement; Tx, treatment. Used with permission.*

Arora, Johnson, Jt Comm J Qual Patient Saf. Schilling, eds.

Technology?

- Can help…but also make it worse…
- Dangers
  - ***Overreliance*** on technology that could minimize verbal communication
  - Ease of ***propagating bad information***

A Word of Caution on Technology

- Computerized sign-out
  - Brigham and Women's Hospital (Petersen, et al. Jt Comm J Qual Improv, 1998)
  - U Washington (Van Eaton, et al. J Am Coll Surg, 2005)
- IT solutions alone cannot substitute for a **"successful communication act"**
  - Human vigilance still required

In an emergency room, the replacement of a phone call for critical lab values with an electronic results-reporting system with no verbal communication resulted in 45% (1443/3228) of urgent lab results to go unchecked.

Ash, Berg, Coiera. JAMIA, 2004 and Kilpatrick, Holding. BMJ, 2001.

CoPaGA Syndrome

- CoPaGA = Copy Paste Gone Amok
- *Repeated highlighting, copying and pasting text from past EHR notes into current notes, the physician-victim attains several goals;*
  1. *avoiding time-consuming work of talking to patient*
  2. *building a documentation trail that portrays faux work*
  3. *crowd-out of useful information by gluts of useless data*
  4. *zombie-like propagation of inaccuracies that persist*

74% of physicians in a community hospital saw cut/ paste problems in signout

TMI?

- Overreliance on signouts for other work
  - Become unnecessarily long "shadow chart"
  - Often becomes a personal tracker of information
    - "cognitive artifact" like a grocery list
- Loses is primary function for the receiver
  - Information overload

Buy-In & Sustainability

Intrinsic motivation to improve vs. extrinsic "top down incentive"

- Locally created
  - "not invented here"
  - Post process map to solicit comments
- Local ownership
  - Standard language resonates with staff
  - Modifications made by front line users
- Local leadership
  - Train the trainer
  - peer champion approach

Monitoring

- Desired
  - Periodic
  - Unscheduled
  - Not cumbersome
  - Solicit usable data

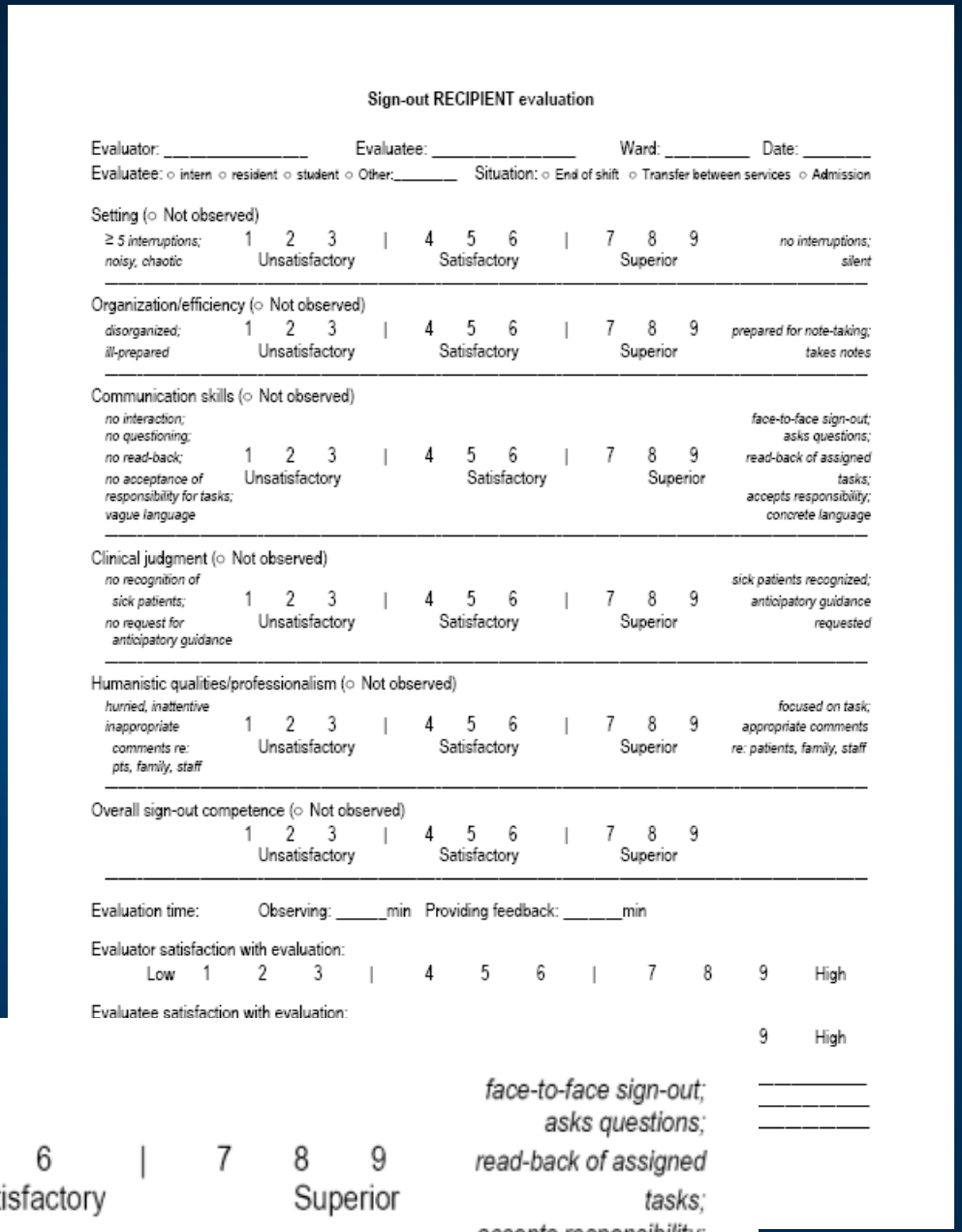
- Peer evaluations or 3rd party evaluations?

- Retrospective
  - End of rotation
  - End of week
  - End of month

- One time evaluations

Hand-off CEX

- Based on "Mini- CEX" instrument widely used in internal medicine
  (Norcini, et al, 2003)
- Domains assessed:
  - Organization/Efficiency
  - Communication skills
  - Clinical judgment
  - Professionalism
- 9-point scale



Sign-out RECIPIENT evaluation

Evaluator: _____ Evaluatee: _____ Ward: _____ Date: _____

Evaluatee: ○ intern ○ resident ○ student ○ Other:_____ Situation: ○ End of shift ○ Transfer between services ○ Admission

Setting (○ Not observed)

≥ 5 interruptions; noisy, chaotic — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — no interruptions; silent

Organization/efficiency (○ Not observed)

disorganized; ill-prepared — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — prepared for note-taking; takes notes

Communication skills (○ Not observed)

no interaction; no questioning; no read-back; no acceptance of responsibility for tasks; vague language — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — face-to-face sign-out; asks questions; read-back of assigned tasks; accepts responsibility; concrete language

Clinical judgment (○ Not observed)

no recognition of sick patients; no request for anticipatory guidance — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — sick patients recognized; anticipatory guidance requested

Humanistic qualities/professionalism (○ Not observed)

hurried, inattentive; inappropriate comments re: pts, family, staff — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — focused on task; appropriate comments re: patients, family, staff

Overall sign-out competence (○ Not observed)

1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior

Evaluation time: Observing: _____min Providing feedback: _____min

Evaluator satisfaction with evaluation:

Low 1 2 3 | 4 5 6 | 7 8 9 High

Evaluatee satisfaction with evaluation:

9 High

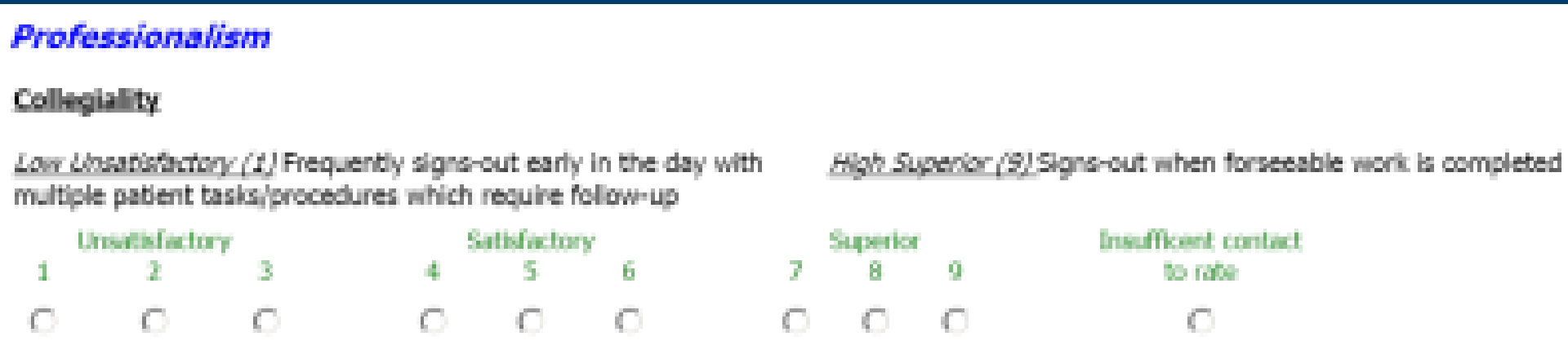
Communication skills (○ Not observed)

no interaction; no questioning; no read-back; no acceptance of responsibility for tasks; vague language — 1 2 3 Unsatisfactory | 4 5 6 Satisfactory | 7 8 9 Superior — face-to-face sign-out; asks questions; read-back of assigned tasks; accepts responsibility; concrete language

Intern Peer Evaluations

- Competency-based
- Anonymously delivered via New Innovations at end of inpatient medicine month

  - •delivering signout (updated written sign-out, etc.)
  - •receiving signout (listening behavior, cross-cover, documentation of overnight events, etc.)



Professionalism

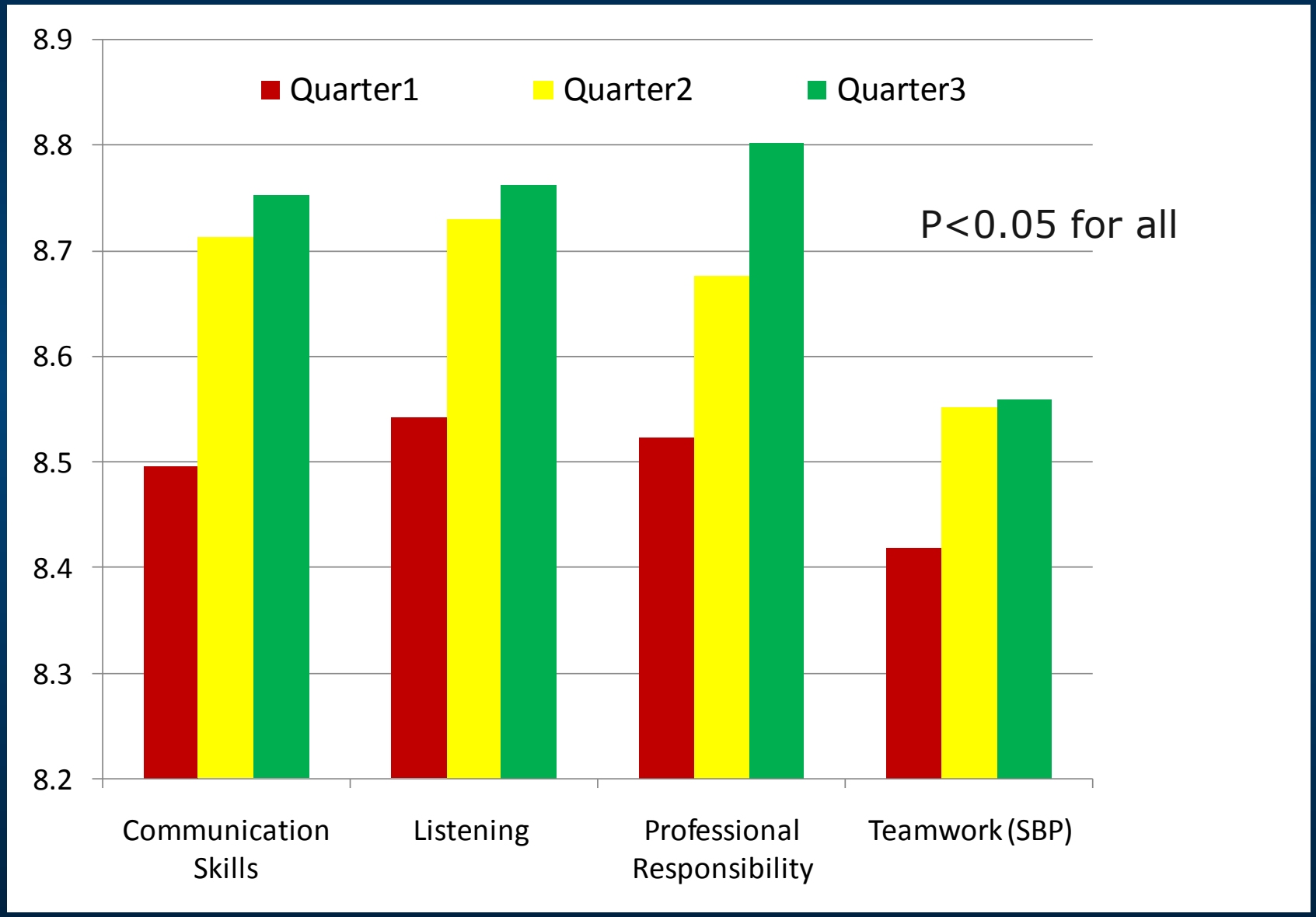
Collegiality

Low Unsatisfactory (1) Frequently signs-out early in the day with multiple patient tasks/procedures which require follow-up

High Superior (9) Signs-out when foreseeable work is completed

Unsatisfactory			Satisfactory			Superior			Insufficent contact to rate
1	2	3	4	5	6	7	8	9	
○	○	○	○	○	○	○	○	○	○

Improvements over Time

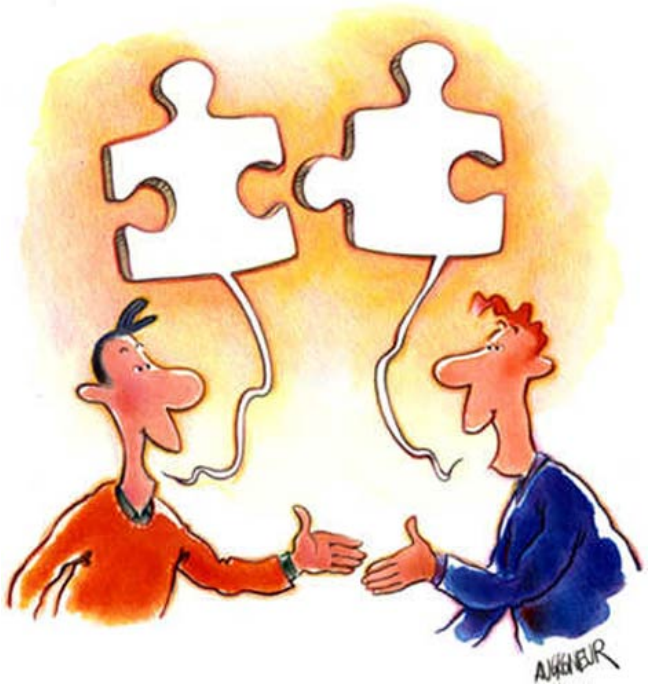


So What Can Senders Do?

- Think about the **"R"eceiver (4Rs)**
- **Relevant** items that will be **Remembered**
  - Focus on sickest patients first
  - Daily progress (today's baseline, updated events)
  - Direction → To Do Items and If/then items
- Directions with **Rationale**
  - avoid ambiguity → "check CBC" without giving a reason why and what to do with results
- Check for **receiver** understanding
  - Encourage questions and **read-back**
  - Overcome egocentric heuristic (think about receiver)

Handoffs are a Two Way Street

- Best understood as a *dialogue*
  - an interaction that fosters common ground, empathy, and equity to transfer necessary information



- Sender must paint a picture…
  - BUT receiver must see it, understand it, act on it, and, ultimately, communicate it to someone else

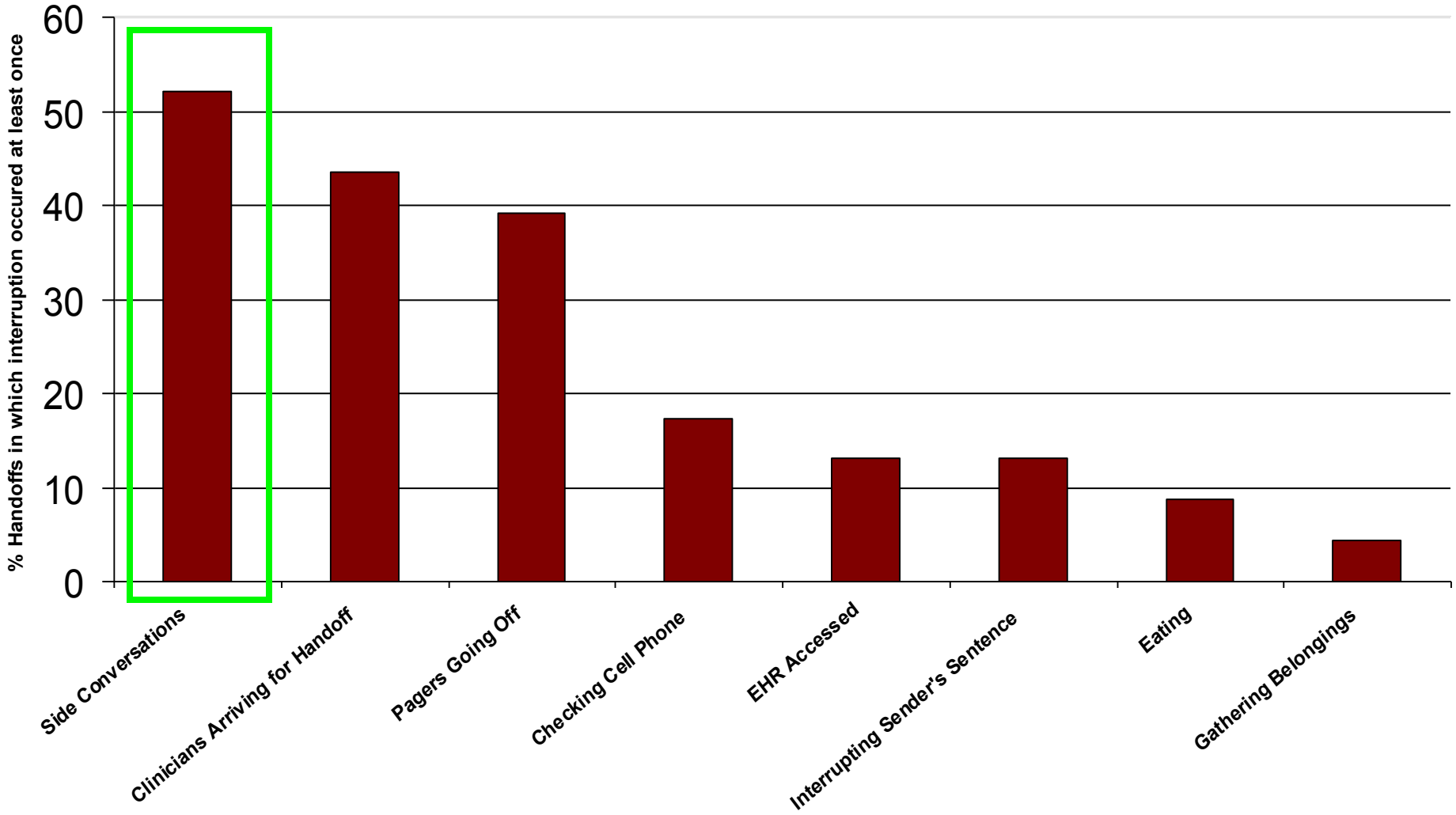
Gibson CS, et al. Ann Emerg Med 2009

What Can Receivers Do?

- Actively listen
  - stay focused, limit interruptions, taking notes can enhance memory
- Ask questions
  - to ensure you understand directions
  - the handoff is your learning opportunity
- Use a system
  - to keep track of to do items that require your action
- Readback
  - directions to ensure you are on the same page

Handoff Interruptions on Hospitalist Service

(n=71 interruptions in 23 handoffs)



Findings

- The hand-off is discipline specific with a high degree of variation
- Universal guiding principles:
  - Not a one-size fits all: respect technical, cultural, and environmental differences
  - Understand and aim to reduce variation
    - Focus on required verbal communication
  - Transfer content AND professional responsibility
  - “Close the loop” on all hand-off communications
  - Clear roles and back-up behaviors to keep it patient-focused

What Can Leaders do?

- Emphasize the importance of handoffs
- Create a standard protocol
- Optimize process and environment
  - Provide overlapping shifts
  - Dedicated time and place
  - Limit interruptions (when possible)
  - Provide additional time for side conversations to occur
- Provide communication training

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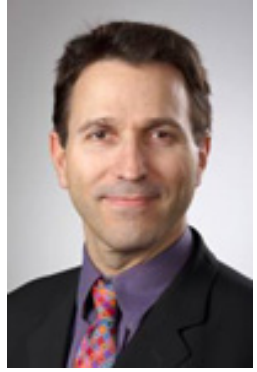

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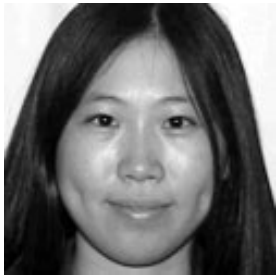

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Beware technical, cultural, and environmental differences

- A "one-size fits all" approach does not allow for customization.
- Environment
  - Although 4 programs had a designated hand-off location, 3 conducted hand-offs wherever convenient
- Culture
  - One resident describes being a "slave to 'The List' [sign-out sheet]" and "information overload"
  - In a different program, only acutely ill patients are on the sign-out
- Technical
  - While all disciplines hand-off "administrative data" (i.e. name, MRN, room number, etc.), major differences in specific categories
    - Surgical fields: Pre-op consent, post-op checks, etc.
    - Pediatrics: Custodial issues (DCFS, parents, etc.)
  - Common use of some language: "If/Then" for contigency planning

Applications of Standard Language

- "Read-back"
  - Reduces errors in lab reporting

"Read-backs" at your neighborhood Drive-Thru

Table 2
Description of Errors

Description of Error	No. (%) of Occurrences
Incorrect name of patient	10 (34)
Incorrect test result	9 (31)
Incorrect specimen/test repeated	6 (21)
Recipient refused to repeat message	4 (14)
All	29 (100)

29 errors detected during requested read-back of 822 lab results at Northwestern Memorial Hospital. All errors detected and corrected.

Barenfanger, Sautter, Lang, et al. Am J Clin Pathol, 2004.

The Role of Human Factors in Handoff Quality

Bobbie Dietz

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Patient Safety Listed PSO Organization

What do Human Factors have to do with Handoffs?

- Handoffs pose numerous human factors engineering (HFE) implications
- Human factors (ergonomics) focus on behavior and interaction between human beings and their environment
  - Distractions, stress, interruptions, fatigue, noise, common language, memory, resistance to change
  - Incomplete or omitted information (medical record or from sender)

What Human Factor Contributes to the Greatest Risk of Error During Handoffs?

Communication problems

- 31% communication exchanges involved interruption
  - roughly 11-15 interruptions an hour
- Communication lapses accounted for 26 percent of all reported errors
- Language barriers
- Interpersonal communication skills of caregivers
- Knowledge and experience level of caregiver
- Communication breakdowns were a contributing factor in 43 percent of incidents*
  - two-thirds of these communication issues were related to handoff issues

* Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 2 **Chapter 34. Handoffs: Implications for Nurses**

Build-Don't Break-communication During Patient Handoffs

- Obstacles to good communication involve both individual and systemic problems
- System problems include lack of formal hand-off procedure
- Individual factors, such as resistance to change, can create communication barriers as well

Human Factors, Barriers and Strategies*

Human Factor	Barriers	Strategies
Communication	different dialects, accents, & nuances	• face-to-face handoff is "preferred" • standardized forms, checklists, or tools
Distractions	situational factors can contribute to distractions	• provide handoff in a location/environment that minimizes distractions
Interruptions	occur frequently	• provide coverage of other duties during handoff to support focused transition

**Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 2*

Human Factors, Barriers and Strategies

Human Factor	Barriers	Strategies
Noise	background noise such as pagers, phones, etc.	use “read back” to decrease communication errors
Fatigue	increased errors are noted in nurses working prolonged shifts	limit amount of hours worked
Memory	sort-term memory limited & lapses may occur when large amounts of info are communicated during a handoff	use preprinted patient information forms for accuracy & completeness of information

Human Factors, Barriers and Strategies

Human Factors	Barriers	Strategies
Written communication	trying to interpret illegible notes from another provider may create errors in communication	• use electronic strategies to decrease problems with illegibility • use standardized processes to assure clinical information is communicated
Variation in processes	may be wide variance in way a handoff is conducted that may lead to omission of critical information & contribute to medical errors	• adopt a standardized, consistent approach to the handoff

Validated Human Factor Issues that Affect Handoff Quality*

General	Sending	Receiving
Expectations between sender & receiver differ	Sender provides inaccurate or incomplete information	Receiver has competing priorities and is unable to focus on transferred patient
Ineffective communication method – verbal, recorded, bedside, written	Sender unable to provide up-to-date information	Receiver unaware of patient transfer
Interruptions occur during handoff	Inability of sender to follow up with receiver if additional info needs to be shared	Lack of responsiveness by receiver
Inadequate staffing at certain times of the day or week		

* Joint Commission Center for Transforming Healthcare – Handoff Project

How Do You Improve Human Factor Issues in Handoffs?*

- Need for common language for communicating critical information
- Provide standard communication framework
- Allow opportunities for providers of care to ask and resolve questions
- Incorporate repeat back and read-back steps
- Implement technologies like electronic handoffs

* WHO Collaborating Centre for Patient Safety Solutions May 2007

Incorporate Human Factors in Handoff Training

Enhance ability of providers to communicate effectively by taking advantage of knowledge about human factors (why we make errors)

- Training for healthcare professionals does not equip people with the theories, knowledge or tools to understand or evaluate the complexity of behaviors in handoffs*

* Handbook of Human Factors and Ergonomics in Health Care and Patient Safety -Handoffs and Transitions of Care

Resources

"A Model for Building a Standardized Hand-off Protocol" by Vinnet Arora, MD, MA

Patient Safety and Quality: An Evidence-Based Handbook for Nurses: Vol. 2

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Upcoming Handoff Series

Series	Topics	Dates
Part 3	Design and implement effective training programs Develop metrics to monitor handoff effectiveness	March 20
Part 4	Examine the use of technology in handoffs Share success stories	April 24

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