

Hand-Off Communication: A Patient Safety Strategy

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In 2006, the Joint Commission Sentinel Event report indicated that an "evaluation of more than 3,000 root cause analyses done from 1995 to 2004 found that more than 65% of sentinel events in accredited health care organizations were caused by communication problems; in 2005, that percentage was nearly 70%."

Experts agree that breakdowns in hand-offs are a leading cause of malpractice or lawsuits, and the Princeton Insurance claims database indicates that communication issues represent one of the most common risk management issues.

In healthcare, the transfer of information between providers and patients and among providers themselves is a process that is at the crux of, and can either define or hinder, optimum care. It is for this reason that the Joint Commission has included the improvement of communication among providers and the standardization of hand-off communication as a National Patient Safety Goal.

Dr. Christopher Landrigan, director of the Patient Safety Program at Brigham and Women's Hospital in Boston, defines "handoff" as the transfer of patient information and responsibility between healthcare providers. He calls this a critical point of vulnerability for communication errors.

Oftentimes, the interaction between staff in the hospital is hurried and involves various styles of communication. Recognizing this problem-prone and high-risk period, patient safety advocates recommend standardizing the approach to handoffs in order to improve the

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effectiveness of communication. The goal of standardizing handoffs is to bridge the gap between the narrative methods used by the sender in explaining a situation and the receiver's desire to hear only the "headlines" of a situation.

Ideally, an effective handoff should be uninterrupted and allow for an interactive exchange of relevant patient information. This gives the incoming caregiver an opportunity to clarify any uncertainties and review relevant patient history or information. It should also require the use of a repeat-back process for the verification of the received information.

Current review of literature on the implementation of standardized methods of handling patient handoffs indicates that different institutions are at different stages of development; however, it also demonstrates ongoing activity in improving the process.

One of the most common techniques extensively used is the **SBAR** method and was recently reformulated to include another **R (+R)**. The acronym stands for:

- S** – Situation: What is happening at the present time?
- B** – Background: What are the circumstances leading up to this situation?
- A** – Assessment: What do I think the problem is?
- R** – Recommendation: What should we do to correct the problem?
- R** – Repeat Back: Review - What did we decide to do?
The process continues until a "shared" understanding is verified.

SBAR + R can be used in nearly any communication medium, in both urgent and critical situations. It helps a person organize his or her communication in a way that ensures common understanding and avoid confusion and potential gaps in the transfer of information.

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Some organizations have developed modified versions of SBAR+R. The following are other examples:

SHARED (Situation-History-Assessment-Request-Evaluation-Document) is a system developed at Northwest Community Hospital in Arlington Heights, Illinois, to better meet their individual needs.

ANTIC-ipate (Administrative information: e.g. patient name and location, New information: clinical update, Tasks: preferably in an "if-then" format:, e.g. if hematocrit=X, then transfuse, "Is the patient sick?: an assessment of severity of illness, Contingency planning and code status) is a method and technique developed at the University of San Francisco and the University of Chicago.

Ticket to Ride, a series of questions to be asked of and answered by transporters bringing patients from one department to another, was developed at St. Joseph Health System in Orange, California.

All these techniques and others that are yet to be published are indications that the healthcare community has taken this patient safety goal seriously.

Where does handoff apply? The locations where it commonly takes place are:

- Change of shift
- Nursing to physician communication
- Physician transfer of complete responsibility during vacation coverage
- Physician transfer of on-call responsibility
- Physician transfer of responsibility to a hospitalist
- Nurse temporarily leaving a unit for break
- Nurse and physician handoff from patient registration to the inpatient unit (admitting physician to attending physician and admission staff to unit RN)
- Physician handoff upon transfer to another hospital setting

The standardized approach to communication promotes clear and direct

guidance in providing important clinical information and discourages vague language such as the patient "is crashing," "going downhill" or "a little unstable."

Another important application of this method is especially important during planned absences by the medical staff. The use of a hand-off document, either on paper or by email, to the covering physician provides pertinent information about current treatment and condition as well as about any recent or anticipated changes. This process should provide a timeframe sufficient for the receiving physician to review the information and request any additional information if needed. A similar document will also be provided by the covering physician on the return of the physician taking leave. This will be followed by documentation in the physician progress note that this exchange occurred.

As in any new initiatives, there may be barriers to effective implementation of a handoff program. However, these barriers can be overcome by seeking input, listening to concerns, and educating the care providers on the benefits of SBAR+R, i.e. "this technique helps to provide clear and concise information when physicians are called in the middle of the night, and it decreases tension and streamlines work and communication."

Finally, good design and support for the program, as well as recognition by all team members that this is an important patient safety initiative, will ensure successful implementation. ❖

Resources

1. Joint Commission Resources: Improving handoff communications: Meeting National Patient Safety Goal 2E Patient Safety 6:9-15, Aug. 2006.
2. ECRI: Healthcare Risk Analysis, July 2006 Supplement A, Risk and Quality Management Strategies 17. Communication: Healthcare Risk Control System Tools
3. CRICO/RMF, FORUM: Reducing Risk During Handoffs. March 2007 Vol 25. No 1
4. AORN: Handoff Toolkit
5. OR Manager Inc. A SHARED tool Strengthens Handoffs. OR Manager, Vol 22 No.4. April 2006
6. Ascension Health Systems: Lourdes Perinatal SBARR Report, 2006, Seton Health Network, SBAR Report
7. Greenberg CC, Regenbogen SE, Studdert DM, et.al. J Am Coll Surg 2007; 204: 533-540 Patterns of Communication breakdowns resulting in injury to surgical patients.