

Patient Hand-Offs

What's the Big Deal?

“Hand-offs” in patient care—when care of a patient is transferred from one physician to another—is a critical point in continuity of care. This is when information is exchanged concerning the care of the patient by one physician to the next. Many factors such as timing, incomplete information, poor relationships, and location where hand-offs occur can influence the quality of a patient hand-off. Hand-offs occur in all health care settings—in a physician’s office when a patient is referred to a specialist, in noisy and chaotic emergency departments, on hospital floors, or among anesthesiologists who may be covering several surgeries at once.

Information exchanged during hand-offs includes pertinent data such as the patient’s demographics, current status, pending labs and radiology scans, medications, procedures, and the future plan of care. In addition to the concern for the smooth transfer of patient care, physicians should also be aware of the potential for disastrous legal consequences if something goes wrong during this exchange of information.

Malpractice lawsuits stemming from failed patient hand-offs often result in two defendant physicians pointing fingers at each other. This perpetuates contradictory testimony and permits the plaintiff’s attorney to drive a wedge between the defendants which often results in a plaintiff’s verdict. As we know, communication breakdown is a leading cause of medical malpractice cases.

Communication problems were the primary cause of 65 percent of sentinel events between 1995 and 2004, according to The Joint Commission. Moreover, in 2005, The Joint Commission found that 70 percent of sentinel events were actually caused by communication breakdowns, half of which occurred during patient hand-offs.¹ As a result of these startling figures, The Joint Commission called upon hospitals to implement a “standardized approach” to hand-offs or risk losing their accreditation.

The Joint Commission has not told hospitals exactly how to effect quality hand-offs, but has recommended a “standardized” approach. The hospital or organization must define, communicate, and implement a process where patient information is communicated in a consistent manner. Standardization provides a means to educate staff about the process and helps support consistent implementation throughout the hospital. Ideally, the hand-off process should be similar throughout the

¹ Patient Handoffs, Runy, Lee Ann, Hospital and Health Networks at hospitalconnect.com (Last accessed 2/19/2009).

hospital, but practically, the hand-off process may differ from one setting to another. A standardized approach should identify:

- The specific hand-off situations to which it applies;
- Who should be involved in the communication; and
- What information should be communicated (e.g., diagnoses and current condition; recent changes in condition or treatment; anticipated changes in condition or treatment; what to watch for; and opportunities to ask and respond to questions—ideally, in person).²

The Joint Commission's standardized approach is applicable to the physician office setting, as well.

In an effort to improve hand-offs, physicians and hospitals have looked to other industries—such as the airline and nuclear power industry—to learn how to standardize communication in patient care. Tools such as forms and checklists are often used in the hand-off process (e.g., standardized referral forms or letters in physicians' practices). In conjunction with good, interactive communication, physicians and other caregivers involved in hand-offs should have good working relationships built on trust and teamwork—not hierarchical status.

Risk Management for Effective Hand-Offs

1. If possible, communicate directly with the physician who is assuming care of the patient; permit time for interactive communication, and questions and answers;
2. Have access to appropriate medical information (not just your notes on the back of a napkin, for example). The patient's medical record will likely contain answers to questions you may have;
3. When appropriate, conduct hand-offs at the patient's bedside at the hospital. This is especially effective in the emergency department or intensive care units (permitting the oncoming physician to obtain a complete picture of the patient, and allowing the patient and family to be involved in continuity of care);
4. Ensure important patient information is exchanged in both verbal and written form; and
5. Create a team environment among caregivers, so as to foster an environment in which opinions and observations are freely exchanged.

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² Hand-off Communications MPSG.02.05.01, The Joint Commission, www.jointcommission.org (Last accessed, 2/17/2009).