

Handoffs: A Continuing Challenge

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A physician wants to schedule a 52-year-old patient who is in the office for a laparoscopic hysterectomy due to abnormal bleeding refractory to other treatment. She is otherwise healthy. She indicates at the very end of the visit that she wants her ovaries removed because of concern about ovarian cancer. The physician dictates that information in the office note, along with a complete history and physical exam.

The next day, the physician instructs his secretary to send the usual notes and consent form to the hospital operating room “scheduling desk.” The secretary, who is relatively new, sends the last office note she can find—not the one dictated the day before—which only briefly summarizes why the patient will need surgery. She also sends the consent form. The clerk at the operating room scheduling desk files the information in a folder for the day of surgery.

On the day of surgery several weeks later, the nurse assigned to the patient cannot find the consent form sent over by the office. When the nurse is talking to the patient about the surgery, the woman reiterates the desire to have her uterus, fallopian tubes, and ovaries removed (bilateral salpingo-oophorectomy; BSO). The nurse pages the resident assigned to assist on the case and tells her she needs to redo the consent form.

When the resident arrives, the original nurse has gone on break. The resident queries the patient, who says she is here for a hysterectomy, and has her sign a consent for a “laparoscopic hysterectomy.” The resident also does a brief history and physical exam. When the physician arrives, somewhat late due to traf-

fic, he briefly reviews the forms and asks the patient whether she has any questions. She asks none and is taken to the operating room.

A time-out is done prior to anesthesia. The physician indicates during this process that the procedure will be a laparoscopic hysterectomy. Hearing no comment, the surgery proceeds and is carried out without complications. The fallopian tubes and ovaries are not removed.

At a 4-week follow-up in the office, the patient is told the uterine pathology was benign. When she asks if the ovaries showed any abnormality, the physician discovers, to his chagrin, that the surgery was incomplete.

DISCUSSION

This hypothetical case illustrates how failure to accurately communicate information can have significant consequences. Even when errors potentially can be avoided, failure to have an appropriate system of handoffs can thwart such efforts. For this article on the subject of handoffs, we discuss the strategy for analyzing and formulating a process, determining content, implementation, and monitoring.

Analysis of the Process

The first action, as discussed by Arora and Johnson, is to map out the steps in the process. Essentially, draw a flow diagram of a process as it currently exists, to better understand what areas need to be addressed and who is responsible for each step or portion of a step. In the hypothetical case, one would include as major steps the gathering of information in the office, scheduling of the case, transfer of information to the operating room, review of information at the time of surgery, transfer of information when there are changes of personnel, and the time-out process in the operating room.

During the analysis, one needs to determine whether the process works. Are there

FOCUSPOINT

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unnecessary redundancies or complexity, and how can the process be improved? In this case, the “time-out” process did not clearly indicate that the patient needed to verify the surgery to be performed. Further, the surgical discussions and “time-out” assumed that the patient knew the difference between hysterectomy and hysterectomy with BSO. Using more understandable terms, such as removal of the uterus or tubes and ovaries, may also have led to avoidance of this surgical error.

Content

There has been a great deal of attention given to use of the SBAR (Situation, Background, Assessment, and Recommendation) approach for communicating important information during handoffs between health care professionals. For example, in the hypothetical case, the nurse handing over care prior to her break should have indicated the patient was being prepared for surgery (S), the surgery was being done for abnormal bleeding and was going to be a laparoscopic hysterectomy with BSO (B), there were no medical problems but she was awaiting arrival of the resident (A), and that the resident needed to complete the consent form and do a history and physical exam (R). If she had done so, the surgery would likely not have been incompletely performed.

SBAR can also be used for nonmedical transfers of information. When giving scheduling instructions to the secretary in the described case, the physician could state she needs to schedule a laparoscopic hysterectomy and BSO (S), a consent form was completed and a detailed note was dictated the day before (B), there appeared to be no major problems in the prior review of the chart (A), and the material being sent to the scheduling desk should include the consent form as well as the note from yesterday (R). This is another step where the error may have been avoided, since the latest office note describes the intended surgery.

Implementation

Either in the content or implementation phase, develop a checklist for each major step that covers what information needs to be conveyed. At this time, review the overall plan and content with those responsible for each step. This will allow for additional

input and suggestions for improving the overall process. This is also a time to gain buy-in from all persons involved, including both support and professional staff, in order to devise a standardized process. Such an approach will reduce variation, be easier for staff and physicians to follow, and result in less chance of error. In general, the process should be developed into a written policy that can be reviewed and also used to train new staff.

Monitoring

It is important to assess from time to time how the process, as well as the checklists, are working. This is particularly true when the process is relatively new. The review should be done in a group to ensure that input is obtained from all those involved in the implementation of the process.

The group should review, in particular, where the process did not work well and determine why it did not work. This will allow those involved to suggest changes that will reduce the chance of future problems. This is especially important when processes are complicated and involve multiple handoffs. For example, complicated surgery, such as that performed with a robot, may have multiple handoffs related to equipment, as well as several patient handoffs.

CONCLUSION

Refining and utilizing a standardized system of handoffs has many benefits, including a reduction in errors, improved attention to important detail, and better teamwork that not only improves patient safety but secondarily improves overall morale of the team.

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SUGGESTED READING

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FOCUSPOINT

Using a standardized system of handoffs can reduce errors and improve patient safety.