Transitions of Care, Handoffs, and Communication

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Follow-up Workshop Session: Gus M. Garmel, MD and Joanna Law-Courter, MD

This session will focus on education and assessment techniques for faculty and nurses regarding interpersonal and communication skills, with particular attention to handoffs, communication, and consultation. We will discuss why handoffs (also referred to as signout) and consultations are important patient-safety related issues, especially given frequent transitions of care. Following presentation of background information, we will offer strategies to improve handoffs and teach how to interact with consultants using an interactive format (workshop). Finally, the literature pertaining to handoffs and consultations, and taxonomy describing both processes will be discussed.

Objectives: At the conclusion of this session, learners will be able to:

1. Discuss the impact of ineffective and inefficient handoffs in the Emergency Department.
2. Describe the different frameworks for handoffs within Emergency Medicine.
3. Describe and implement strategies to improve handoffs between emergency physicians, between MDs (emergency physicians and consultants/hospitalists), between RNs and EPs, and between RNs (end of shift or during breaks).

I. HANDOFFS (SIGNOUT or HANDOVERS): What we Know
- Consider handoffs a “privilege” (to transfer care), not a “right” (to go home or leave the ED)
- Duty hours and consultations result in more frequent handoffs and patient care transitions
- Handoffs influence patient safety and medical error
- Efficiency during signout must be balanced against details necessary for safe patient care (too much detail may result in “information overload,” missed or forgotten information; not enough detail compromises understanding – both increase risk of error and poor patient outcome)
- Handoff risks include miscommunication, inaccurate/incomplete information, unanswered patient or family questions, patient deterioration or morbidity/mortality
- The new “owner” may not be as dedicated or committed to “someone else’s” patient
- Signout at the bedside with a computer, although rare, is advantageous with complex patients

Purposes of handoffs:
1. Provide a safe transition of ongoing and continued patient care between physicians
2. Allow the opportunity for a fresh perspective or another opinion from a different clinician

Components of handoffs:
1. Patient's name (including name alerts if appropriate) and room # (rooms often change)
2. Clear, concise, synthesis of the patient’s presentation, work-up, likely diagnoses, treatment and disposition (e.g. “an 80-year-old female with CAP who is being admitted/needs to be admitted for initial sats of 88%, now resolved after one Albuterol/Atrovent neb; she lives alone; her vitals are XYZ, she’s on 2L NC Oxygen, unlikely to require intubation (full code), and has received a fluoroquinolone IV”) to frame the handoff discussion. Include how the diagnosis was reached.

3. Pending studies, procedures, and consultations. Offer what you have done (and have not done), and why (or why not). This includes consultations in progress or pending, including names, times called, or times expected.

4. Special circumstances (hard of hearing, translation required, VIP, talkative, medical background, no visitors, family does not want the diagnosis revealed to the patient or the patient has asked not to reveal diagnosis to family); this includes DNI, DNR, code status, hospice, etc.

5. Diagnostic uncertainty. This reduces anchoring bias and diagnostic momentum, both that may increase error. In other words, share what you don't know or what you're unsure of (and why, and how you are sure of things you “know”).

6. Information about private or primary physicians, surgeons, specialists (if appropriate)

7. Allergies or problem medications (if relevant, to explain medication choice or those to avoid)

8. Algorithm decisions (if positive, then… or if negative, then… or if inconclusive, then…), and what remains or is needed to do after test results return (or if pain returns, or if BP drops…)

9. Summary of the ED course

10. Anticipated problems that might develop during the remainder of the ED stay, including treatments that have and have not worked (for pain, breathing, HR, BP, etc.)

11. Identify high-risk handoffs or high-risk patients during your signout

Types of signout in EM (in addition to abbreviated versus detailed):
- EMS to student or physician
- Physician to physician (end of shift or leaving the patient care area for even a short time)
- Student or physician to consultant
- Student or physician to admitting team
- Student or physician to primary care provider (for follow-up)
- Student or physician to accepting hospital or skilled nursing facility (i.e., transfer)

Pearls and Pitfalls:
1. Signout patients often have the highest risk for error, as these patients are often “newer” patients presenting at the end of the provider’s shift (when they may be tired, hungry, distracted, or rushed), often managed or signed over by someone else, or “difficult” patients (personality issues, problem dispositions, chronic medical or social issues, drug-seeking, abusive, etc.)

2. All patients in the ED need to be signed over and accounted for – it is never appropriate to say “you don't need to know about this patient, they're leaving (or they’re admitted)”

3. If you can present the patient and say the same thing in fewer (exact) words, be sure to do it

4. Make sure your recipient understands your approach (i.e., sickest patient first, most complex, longest time in ED, most recent, most remaining to do, room # sequence, alphabetical by name, those going home or being admitted, etc.)

5. Always sign out as if a critically ill patient will need the receiving provider’s attention (which happens often); therefore, sign out efficiently and when this physician is most available

6. Acknowledge that patients signed over are potentially dangerous patients (errors occur), and recognize that these patients often get less attention than a “new” patient or one's “own” patient
7. The receiving provider should take ownership of signed over patients – introduce yourself to the patient(s) and family members, review their records, labs, imaging, medical comorbidities, etc.
8. Consider assessing complicated patients TOGETHER (oncoming physician and outgoing physician) with bedside handoffs or rounds after signout. This allows the oncoming physician to independently verify information, ask questions, and assists with complex patient transitions.
9. Make sure the physician receiving handoff is comfortable asking and has no further questions (and don’t hesitate to ask questions if you have any as the physician receiving signout)

II. CONSULTATION
- Always advocate for the patient’s best interest (everything returns to the patient)
- If a consultant is needed emergently, make this clear (and use the correct paging technique)
- Negotiate the (shared) workload with consultants so that patient care is optimized
- There is no such thing as an “inappropriate” consultation (despite what consultants might say)
- Clarify the purpose of the consult (e.g., an answer to a question, a bedside visit including the necessary time frame, a procedure, or an admission)
- Understand hospital or ED policies if you are uncomfortable with a consultant’s recommendations (especially if a resident consultant is involved, if a consultant “refuses” to see a patient, if a consultant is unavailable, or if an unacceptable amount of time elapses)
- Always be respectful when requesting a consult. Nobody likes to be told what to do, or when and how to do it. Remember “hard on the issues, soft on the people (from Fisher and Ury).”
- Improve relationships with consultants during off-service rotations, committee involvement, social events, etc., when stressors of patient care are not present or may not be as time-sensitive
- Try to understand our consultant’s perspectives, just as we hope that they are willing to consider ours (educate them gently whenever possible)

The Five Cs of Consultation (adapted from Kessler)
- **Contact** – name, position, service, supervisor (if applicable), confirm name of consultant (and service)
- **Communicate** – concise story (history, PE, pertinent labs/studies, ED course), speak clearly, present an accurate account of case details
- **Core question** – specify reason (need) for consultation, specify timeframe for consultation
- **Collaborate** – work together to produce best patient outcome(s); consider incorporating all reasonable suggestions by the consultant
- **Close the loop** – review and repeat (for clarity) patient care plan details; express gratitude

SELECTED REFERENCES:


