Insight and Perspectives

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We are pleased to offer our latest installment of *Insight and Perspectives*. This newsletter is dedicated to sharing healthcare news, trends and developments impacting our broker and insureds.

In this particular installment you will find Kathleen Shostek's article on *Better Handoff Communications Reduce Risk and Improve Safety.*

As always, we appreciate your continued support and thank you for allowing Endurance to be a part of your risk and insurance programs.

About Us

Our U.S. and Bermuda teams provide healthcare professional liability coverage to non-profit and for-profit hospitals and other healthcare organizations.

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Better Handoff Communications Reduce Risk and Improve Safety

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Communication failures, including poor communication during patient handoffs and transitions of care, are leading contributors to sentinel events reported to The Joint Commission (TJC)[1] each year. As defined by TJC, sentinel events are an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof."[2] Sentinel events often lead to patient injuries and potentially significant liability claims or settlements.

In 2006, TJC established a National Patient Safety Goal to improve handoff communications which became an accreditation standard for healthcare organizations in 2010.

Handoff Communication Tools

In an effort to reduce communication failures that contribute to sentinel events, hospitals and other health care institutions are using structured handoff communication protocols, particularly in high risk areas such as labor and delivery.[3] These protocols include well-defined communication tools for the exchange of important patient information and a safe patient handoff. The communication tools can be paper or electronic, and serve to facilitate key patient care discussions during a shift change or other patient handoff. These tools, which commonly rely on mnemonics, can help to clarify information and facilitate cross checking between care teams. It is important to remember that tools are only a starting point. During face-to-face communications, interactive questions should be used to ensure that key clinical information is transferred to the new care giver.

Tools that can help to standardize the handoff process and reduce communication breakdowns include:

- **Ticket-To-Ride.** Used when patients are transported or transferred among departments in hospitals, this is one of the earliest tools developed to improve caregiver communications during handoffs. This written tool is brief but includes important patient information such as allergies, fall risk, sensory impairment, recent pain or sleep medications, time-sensitive treatments, and special needs like supplemental oxygen. For more information, visit: *http://www.nursingcenter.com/journalarticle?Article_ID=858666*

Continued over

- **I PASS the Baton.** Part of the TeamSTEPPS framework to optimize teamwork and communications across health care delivery systems, this mnemonic tool is designed to enhance information exchange during transitions in care. The mnemonic stands for: Introduction, Patient, Assessment, Situation, and Safety Concerns, then Background, Actions, Timing, Ownership, and Next. To access the TeamSTEPPS pocket guide, including the I PASS the Baton tool, visit: *http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html#passbaton*
- **IPASS Handoff Bundle.** In this version of the mnemonic, developed as a standardized approach to teaching, evaluating and improving handoffs, the letters represent: Illness severity, Patient summary, Action list, Situation awareness and contingency planning, and Synthesis by receiver. In a study by children's hospitals adopting IPASS as a handoff communication tool, the medical error rate was reduced by 23% and the rate of preventable adverse events decreased by 30%.[4] For more information on the IPASS Handoff Bundle, visit: *http://www.ipasshandoffstudy.com/about*

Structuring and Monitoring Communication Processes

In addition to communication tools to formalize transmission of information, effective structured handoff strategies should include a defined process and a means for the patient experience to be evaluated. Important aspects to consider when setting up the handoff processes include consistency, scripting communication, encouraging staff to ask clarifying questions, and verifying that information is complete. One way to achieve this is through increased patient engagement during the handoff process.

To promote stronger patient engagement, the Agency for Healthcare Research and Quality developed the Guide to Patient and Family Engagement in Hospital Quality and Safety, a tested, evidence-based resource to help hospitals better partner with patients and families to improve quality and safety. One of the highlighted strategies is for hospitals to have nurses perform handoffs at the bedside with the patient. In addition to reducing the risk of communication errors, patient satisfaction increases with the bedside shift report.[5] Research also shows that engaging patients in their own health care can lead to measurable improvements in safety and quality of care. Higher patient satisfaction scores can generate higher Medicare payments for hospitals as well. For more information, visit: *http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy3/index.html*

To reduce the potential for sentinel events involving communication errors and decrease the liability claims associated with these events, healthcare providers need to routinely validate their handoff processes. This should include monitoring the use of handoff tools and evaluating the contents of handoff documentation, offering direct feedback to providers and staff about the effectiveness of the handoff processes, and implementing needed improvements. ◄

Additional Handoff Communication Resources

Wickline S. [Neuroscience] ICU Handoff Checklist Boosts Patient Safety. MedPage Today 2013 Oct. *http://www.medpagetoday.com/MeetingCoverage/ANA/42271*

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Cornell P., et al, Impact of SBAR on Nurse Shift Reports and Staff Rounding. MEDSURG Nursing. September-October 2014; 23(5):334-42. *http://www.medscape.com/medline/abstract/26292447*

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3. Block, M, et. al., The Tangible Handoff: A Team Approach for Advancing Structured Communication in Labor and Delivery, The Joint Commission Journal on Quality and Patient Safety, 2010. 36(6):282-287.
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