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Smooth Transitions: The Importance of Handoffs for Continuity of Care





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Smooth Transitions: The Importance of Handoffs for Continuity of Care

INTRODUCTION

The Institute of Medicine (IOM) reported that "It is in inadequate handoffs that safety often fails first."¹ A handoff is a complex process that can happen thousands of times a day in a busy hospital or ambulatory care center.² Handoffs occur all along the continuum of patient care between many different members of a healthcare team across many different locations of care. Handoff communications should occur any time the patient moves from one place to another and any time a different person assumes responsibility for the patient.

"To be safe, care must be seamless—supporting the ability of interdependent people... to perform as a unified whole, especially at points of transition."¹

Examples of patient transitions of care where handoffs are recommended include:³

- From emergency department (ED) physician to a primary care physician (PCP) at discharge or in-patient physician
- From hospitalist to hospitalist at shift change
- From hospitalist to specialist during hospitalization
- From PCP to specialist and back
- From nurse to nurse during shift change and temporary relief of coverage during shifts
- Among members of clinical disciplines, e.g., respiratory therapy, physical therapy, imaging
- Between different levels of care within a hospital (e.g., intensive care unit to step-down unit or postanesthesia care unit (PACU) to medical-surgical unit)
- · Between external facilities or from one location of care to another

ELEMENTS OF AN EFFECTIVE HANDOFF PROCESS

A successful handoff process increases patient safety and can decrease liability risk through a combination of accurate transfer of patient information and clearly stated practitioner responsibilities. Raising concerns is essential, when patient deterioration is noted, but factors such as hierarchy and organizational culture can negatively impact team members' willingness to raise concerns.⁴ Leadership's demonstrated commitment to standardizing a handoff process includes establishing a workplace culture in which members of the healthcare team respect each other and value teamwork.

Additionally, an effective handoff process includes:^{5,6,7}

- Involvement of end users in the development and evaluation of handoff processes and forms.
- Consistency (e.g., information is updated in the same way at every handoff).
- Face-to-face handoff communication whenever possible, during which nonverbal cues can improve the transfer of information, particularly when the patient's situation is complex.
- Adequate time for meaningful engagement free from interruptions.
- Multidisciplinary input, including bedside handoff with patient and family involvement.
- Standardized communication tools, such as Situation, Background, Assessment, Recommendation (SBAR) or Introduction, Patient, Assessment, Situation, Safety, Background, Actions, Timing, Ownership, Next (IPASStheBATON).
- A clear transfer point of patient responsibility from one provider to another.
- Integration in the electronic health record.
- Ongoing monitoring and evaluation of the effectiveness of the process.
- Use of closed loop communication, which allows all involved to share information and verify the message is understood.

Fig. 1. Agency for Healthcare Research and Quality, Closed-Loop Communication, revised May 2023, *Pocket Guide TeamSTEPPS® 3.0: Team Strategies & Tools to Enhance Performance & Patient Safety*, <u>https://</u> www.ahrq.gov/sites/default/files/wysiwyg/teamstepps-program/ teamstepps-pocket-guide.pdf

(Permission obtained for use from Agency for Healthcare Research and Quality).

The primary goal of the handoff is to accurately and consistently transfer patient information in a way that provides an oncoming clinician the most current patient status to ensure continuity of care and patient safety. Each organization should select one handoff tool and require its use at every transition of care and review simulation-based trainings or competency trainings scenarios to ensure the handoff process is a component of the education. All members of the healthcare team can make a difference in increasing handoff safety. The key to handoffs is consistency.⁸



ROOT CAUSES OF HANDOFF COMMUNICATION FAILURES

The Joint Commission has identified the top root causes associated with handoff communication failures. These include:⁵

- Using an ineffective communication method (e.g., voicemail; over the phone).
- Not routinely using standardized communication tools.
- Having the handoff and physical transfer of the patient occur at different times.
- Spending inadequate time engaging in communication and asking questions.
- Interruptions or distractions during handoff communications.
- Not including the patient in the discussion.
- Providing inaccurate or incomplete information to the receiver.
- Senders not adequately familiarizing themselves with the patient issues before the handoff.
- Outstanding studies or lack of current information at handoff.
- Inability of the sender to contact the receiver for handoff communication or vice versa, inability of the receiver to contact the sender for additional information following handoff.
- Lack of awareness by the receiver, that a patient has been handed off to them.

The Joint Commission emphasizes the importance of healthcare organizations using a process to identify causes of handoff communication failures and improvement barriers, and then identifying, implementing, and validating solutions to the failures and barriers.⁵ Substandard, disorganized handoffs—even if they do not result in patient injury—can add to patient dissatisfaction. As studies have shown, it is not necessarily substandard medical care that leads patients to file a malpractice lawsuit. In many cases, patients are simply angry about the way they were treated,⁹ about the lack of communication they received, or because they had unrealistic expectations around outcomes. Not surprisingly, many of the root causes discovered by The Joint Commission are also found in malpractice claims. Utilizing the risk reduction strategies presented here can improve handoff communications, which can lead to fewer preventable patient harm events, fewer malpractice lawsuits, and greater continuity of care.

HANDOFF VS. HUDDLE: WHAT'S THE DIFFERENCE?

	Handoff ¹⁰	Huddle ¹¹
What is it?	 A short meeting in which the transfer of critical information, authority, and responsibility for a patient's care occurs from one or a set of caregivers to oncoming staff A communication tool for use across the continuum of care A Joint Commission national standard since 2010⁵ 	 A short meeting in which select patients are discussed but the main purpose is to understand any obstacles to unit, department, or office operations including staffing challenges, medication shortages, equipment concerns, and other issues affecting the day's workflow or progression of care A pathway to escalate concerns to management and executive administration and other members of the chain of command A key practice of high reliability organizations (HRO)
Who attends?	 The team members responsible for the direct care of the patient (i.e., the "sender" and "receiver") 	• The entire interdisciplinary team, by dividing members into tiers, with in-person meetings occurring at designated times (e.g., tier 1— frontline staff (0700), tier 2—facility management (0800), Tier 3—facility administrators (0900)
When is it conducted?	 At critical transfer points in a patient's care 	 At fixed times each day in the same location (e.g., unit lounge or conference room) Before the first patient appointment of the day in outpatient or ambulatory settings
Why do it?	 To transfer information and responsibility from one clinical team member to another To build a culture of collaboration and quality To improve patient safety To bridge the gap in communication styles between team members 	 To maintain a high level of awareness of operational conditions, among all staff and leadership of a practice or facility¹² To enhance interdisciplinary team communication To build a culture of collaboration and quality To improve patient safety To promote fewer interruptions during the workday To review workflow issues proactively
How is it done?	 In-person whenever possible Using standardized communication tools (e.g., SBAR) With buy-in from leadership and members of the healthcare team 	In-person whenever possible





CASE ONE: Your Patient or Mine?

Each transition of care during a hospitalization can increase the risk of a patient harm event occurring, with fragmented care the norm in teaching hospitals. University of California San Francisco's Internal Medicine residency program estimated that nearly 4,000 handoffs or transitions of care can occur per day (1.6 million per year) when adding up all the provider-to-provider handoffs in their institution.¹³ That presents a staggering number of opportunities for error. Any handoff process should provide for an unambiguous transfer of responsibility. It should be easy for the handoff team to determine who is responsible for which duties at any stage of patient care.

Consider how the outcome in the following case could have been different if the two physicians had mutually determined who was responsible for the patient, and when that responsibility began and ended.



Fig. 2. Handoff: Use a Handoff Tool for Optimal Patient Transitions of Care, AHA TeamSTEPPS® Video Toolkit, accessed July 31, 2024, <u>https://</u> www.aha.org/center/project-firstline/ teamstepps-video-toolkit/handoff

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Day One The patient presented to the ED. He reported a one-day history of right leg numbness and a severe burning, pinprick sensation radiating from his right hip to his toes. His history was significant for nausea, vomiting, and poor appetite for the past month, and long-term diabetes. The ED physician ordered venous ultrasound of the patient's right leg, which was negative for venous clots; a CT scan of the brain; x-rays of the lumbar spine and hip; and an EKG. All were essentially normal.

The patient was admitted to the hospital for further evaluation. According to the medical records, the admitting hospitalist saw the patient at the beginning of his shift when he performed a history and physical exam (H&P). He ordered an MRI to rule out neuropathy and an abdominal ultrasound to rule out pancreatitis. The admitting hospitalist testified during his deposition that he did not have independent memory of the patient but that his standard practice was to leave a voicemail sign-out to the hospitalist covering the next day. The H&P was the only contact the admitting hospitalist had with the patient, who was responsible for the care of 100-120 patients during a shift.

Following the admitting hospitalist's examination of the patient and voicemail handoff, a nurse documented that the patient's right leg was cooler than the left, and the right pedal pulse was weak. The admitting hospitalist was not in the practice of reviewing nursing notes. He expected nursing staff to directly report any concerning changes in a patient's condition. Further complicating communication, the admitting hospitalist was in the habit of "handing off" patients after examining them instead of at the end of his shift. Consequently, the admitting hospitalist completed his handoff before the nurse discovered changes in the patient's leg. The nurse did not alert the admitting hospitalist directly, so he did not pass the information to the next hospitalist (rounding hospitalist 1). Unfortunately, rounding hospitalist 1 also was not in the habit of reading nursing notes, so she did not become aware of the critical information.

- **Day Two** Rounding hospitalist 1 ordered a neurology consultation, believing the cause of the patient's leg pain and numbness was radiculitis. This was her only entry in the patient's record over two days. During her shifts on days two and three of the patient's hospitalization, nurses consistently noted the patient's right foot was cooler than his left, and his right dorsalis pedal pulse was weak. But rounding hospitalist 1 relied on nurses to bring this type of patient information to her attention. Because no member of the nursing team communicated this finding to rounding hospitalist 1 directly, she did not report the leg symptoms to the consulting neurologist.
- **Day Three** The neurologist assessed the patient. He believed the patient's symptoms indicated an acute complex regional pain syndrome. He diagnosed the patient with multifocal neuropathy and ordered gabapentin. Before and after the consultation, two different nurses documented the patient's right foot was cooler than his left, and his right dorsalis pedal pulse was weak. The neurologist would later testify that it was his practice to review the physician progress notes, but he did not review nursing notes. His documentation did not indicate the same symptoms found by the nursing staff regarding one leg cooler than the other or a weakened pulse.
- **Day Four** Rounding hospitalist 2 assumed care on day four, continuing until discharge on day seven. She would later testify in her deposition that she had no independent recollection of the patient other than a faint memory that one of the nurses at some point informed her that a pulse in the patient's right leg was decreased. Since this patient was being followed by a neurologist for his leg symptoms, and had already been diagnosed with multifocal neuropathy, she believed she was relieved of any duty to further investigate a cause of the patient's leg symptoms. Thus, she would not have ordered an arterial doppler ultrasound, the test required to determine an arterial occlusion. Her focus was the patient's possible pancreatitis.
- Day Eight The patient was readmitted within 24 hours, diagnosed with extensive atherosclerotic disease, multiple filling defects from the common iliac artery down to the femoral artery, and no blood flow in the lower right extremity, below the popliteal artery. Embolectomy and infusion of tissue plasminogen activator (tPA) were ineffective in relieving the blockage, and the patient's lower extremity was partially amputated. He filed a malpractice lawsuit against all members of his treatment team and the hospital.



DISCUSSION

Rounding hospitalist 2 had the last opportunity to consider other possible diagnoses which may have saved the patient's leg, but she deferred to the neurologist, who had never assumed responsibility. If she had contacted the neurologist to relay the nurse's observations, the neurologist could have reconsidered his diagnosis. If she had realized that the neurologist had not assumed responsibility, she might have more fully considered the nurse's report. The absence of any one provider accepting responsibility for driving patient care—due to confusion from lack of a handoff protocol—played a significant role in the deterioration of the patient's medical condition.

This case was settled prior to trial because of concerns that a successful defense for the hospitalists and neurologist would not be possible without casting blame on each other or finger-pointing at nursing staff. For example, rounding hospitalist 2 had testified in deposition that she relied on the neurologist once a diagnosis was made. The neurologist testified he believed the hospitalists had an independent continuing obligation to review the patient's care and assess whether there was an arterial cause of the symptoms. However, experts opined that all the physicians who saw the patient in the hospital had an independent obligation to assess the patient clinically and consider an arterial root cause for his symptoms.

An underlying benefit of handoffs is that the receiver brings a "fresh pair of eyes" to the patient's circumstances, providing the ongoing possibility of discovering an unrecognized problem. Although expert opinion was mixed on whether the physicians had a duty to review the nursing notes, this lawsuit suggests that physicians should review nursing notes and that nurses should bring relevant information to the attention of physicians. Patient safety relies on a certain amount of redundancy. Regardless of nurse-physician communication duties, the failure to realize the patient had symptoms of arterial occlusion negatively affected each physician handoff. At their depositions, the plaintiff's attorney asked the defendant physicians what they would have done if they had been aware of the information available in the nursing notes. Each admitted they would have ordered testing to determine whether the patient's symptoms were caused by arterial occlusion. At trial the physicians would have to defend their willful ignorance of the information in the nursing notes by suggesting the nurses' duty to communicate that information directly to them excused their inaction. This line of defense was not expected to resonate with jury members.



RISK REDUCTION STRATEGIES

Consistently safe and effective handoffs require a concerted effort by the healthcare team members, leadership, and administrators. Ideally all important patient information is passed from one member of the healthcare team to another during handoff. Sometimes circumstances may require the receiving provider to research further when handoff communication is lacking. Do not hesitate to ask for clarification if information is unclear or for additional information that you cannot locate like the results of a test. Becoming passive and relying only on information that is pushed forward can result in important elements in the diagnostic process being missed.

CLINICIANS AND STAFF

Consider the following strategies:14, 15

- Be familiar with handoff protocols that apply to your patients, keeping in mind that other units and facilities may have different protocols.
- Actively engage in the handoff process by encouraging questions and discussion. Only those involved in direct patient care should be able to hear or view protected health information.
- Before handing off a patient, critically assess the record to detect abnormal values/findings and inaccuracies and identify key issues that need to be clarified for the next period of care.
- Check the nursing record, or talk to the patient's nurse, to ensure you report an accurate patient status to the next provider.
- Communicate a succinct overview of the patient's course while he or she was in your care. This may require an additional personal assessment of the patient if it has not been done recently.
 - ► To organize reporting, use a handoff tool (e.g., mnemonic, checklist).
 - ► Have laboratory and imaging studies and the patient's progress notes available for review with the person receiving the patient.
 - > Highlight pending studies and consultations.
 - ▷ Anticipate results and present contingency plans if the results are not as expected.
 - Draw attention to and have plans for patients with potential management issues that could arise shortly after handoff (e.g., if an MRI has been ordered to rule out serious spinal pathology, identify a responsible physician for the receipt of the MRI report, confirm the physician is ready and available, and discuss the treatment plan).
- Establish who will take primary responsibility for the patient after handoff (e.g., if the neurology service will determine patient disposition based on an outstanding MRI, inform the receiving neurologist, and document the neurologist's agreement to the handoff).
- If a handoff discussion with the receiving clinician/staff member is not possible, supplement the handoff documentation in the medical record to the degree necessary to highlight principal issues.
- Pursue complete information from the sender if you are not provided with adequate handoff information, either in a written report or in person.
- Independently review the patient's records after the patient has been handed off to you.
- Document handoff discussion in the record.

ADMINISTRATORS

Consider the following strategies:^{11, 12}

- Prioritize successful handoffs and make them a performance expectation.
- Consider the system and workflows, not just the people who will be exchanging information.
- Research the various handoff tools available (e.g., mnemonic forms, checklists, and patient transport and transfer tools), adapt them to fit your needs, and use them consistently.
- Ensure specialists and generalists have the same understanding of the breadth and duration of responsibility for the patient's care, when and how a specialist's responsibility for a particular aspect of care concludes, and how sending and receiving physicians can confirm successful handoff.
- Strive for consistency in all handoff protocols across units.
 - ▶ Bring contracting physician handoff protocols into alignment with hospital protocols.
- Include description of attending/consultant comanagement responsibilities in protocols.
- Ensure there is a permanent record of handoff documentation.
- Provide standardized training to all members of the healthcare team who are involved in handoffs.
 - > Define and provide examples of what constitutes a successful handoff.
 - Use simulation-based training, which can illustrate the efficacy of various handoff tools, particularly compared to relying entirely on memory to communicate patient information and document transactions.
- Evaluate the handoff process and adjust policies and protocols.
- Identify a workspace that is conducive for handoffs.
- Establish a process that identifies causes for handoff communication failures and barriers to improvement.
- Identify, implement, and validate solutions to address the failures and barriers.



CASE TWO: Do You Have All the Information?

There can be a significant disconnect between what sending and receiving physicians perceive during handoffs. Studies show that 69% of PCPs reported sending patients' histories to specialists all or most of the time. However, only 35% of specialists reported routinely receiving histories from referring PCPs. Similarly, 81% of specialists reported sending reports to referring PCPs all or most of the time, but only 62% of PCPs reported receiving them.¹⁶ It is important to assess the quality of your handoff communication through self-audits or an external consultant for an objective evaluation of your processes. Conducting self-audits, including random audits of information transmitted via all forms (electronically; efaxed; faxed), to other providers to verify receipt and that they arrived timely and completely, is highly recommended.

Consider how the outcome in the following case could have been different if the surgeon had directly communicated with the family practitioner, or if the surgeon's office consistently had morning huddles to review patients.

A postmenopausal patient presented to her Family Practitioner (FP) for vaginal bleeding. She had a history significant for postsurgical deep vein thrombosis (DVT) and pulmonary embolism (PE), for which she was taking warfarin. After a diagnosis of endometrial cancer, she was scheduled for a hysterectomy.

Handoff One: FP to Surgeon

On April 3 the patient presented to the surgeon's office for a preoperative examination, with the surgeon's physician assistant (PA). Because of the patient's DVT/PE history, the surgical PA ordered a bilateral lower extremity venous ultrasound. A DVT or blood clot was identified in the popliteal vein; however, the radiologist could not tell if the DVT was acute or chronic. Results were sent to the surgeon and patient, but not to the FP office.

Handoff Two: Surgeon Back to FP

During the preoperative exam, the patient reported new onset chest pain. The surgical PA referred the patient back to her FP for workup. The following day, the FP saw the patient and cleared her for surgery related to her chest pain complaint.

On April 6 the patient's daughter, who was helping to coordinate her mother's healthcare, called the FP's clinic and left a message asking about the blood clot in her mother's leg identified in the ultrasound, and whether she was going to be bridged with enoxaparin. The FP ordered a seven-day bridge with enoxaparin to be administered prior to surgery. She asked her staff to obtain the studies conducted on the patient's legs that the daughter referred to, but they did not follow through.

On April 9 the FP met with the patient again to discuss the results of her preoperative studies. The patient denied awareness of any abnormal findings on her tests as results were reported to her daughter, only. The FP examined the patient's legs and found no sign of DVT, and a ventilation perfusion scan or VQ scan ordered had also showed no pulmonary emboli. Her clinical judgement was that the clot reported by the patient's daughter was not an issue that needed management preoperatively.

On April 13 the surgeon also determined the DVT was not a contraindication based on the ultrasound report and proceeded with surgery despite international normalized ratio (INR) results not in therapeutic range.

On April 14 the FP talked to the surgeon's nurse to confirm the patient would receive enoxaparin and warfarin until her INR reached 2.0. The surgeon did not receive the message. Concerned with postoperative bleeding, she ordered a one-time dose of warfarin. Surgical discharge instructions directed the patient to resume the presurgical dosage of warfarin after her one-week postoperative check with her FP. Three days after discharge, the patient died from a pulmonary embolism.



DISCUSSION

During litigation the surgeon took full responsibility for going forward with the surgery and for prescribing the incorrect anticoagulation therapy regimen. Although the surgeon was the target defendant in this case, the plaintiff's experts claimed the FP should have taken a more active role in the patient's anticoagulation. They argued that the FP's failure to conduct a thorough clearance exam and directly communicate her anticoagulation plan to the surgeon, contributed to the surgeon's misjudgment and entangled her in litigation, though she was ultimately dismissed from the case.



RISK REDUCTION STRATEGIES

Although there is no way to control the behavior of a receiving physician at a handoff, you can control the information you communicate and the way you document compliance with the standard of care. Consider the following strategies when handing off patients to specialists:^{17, 18}

- Clearly establish expectations regarding communication and levels of anticipated involvement in the patient's care.
 - ► Ask the specialist to copy you on study results, consultation reports, and other information that will be important for the patient's ongoing care.
- Do not rely on patient or family member reports of clinical information that is otherwise available in the medical record.
- Call the specialist when you need to clarify medical information originating with that physician.
- Contact the specialist when it is unclear who will manage medication holds perioperatively, particularly when patients are on anticoagulants.





CASE THREE: Who's Driving the Bus?

Handoffs are frequently viewed as a hospital risk issue. However, many lawsuits are filed because of miscommunication between a patient's specialist and their FP, with each assuming responsibility for aspects of care was with the other. Many of the underlying causes of handoff failures are the same regardless of location of care.

Consider how the FP, pulmonologist, and infectious disease (ID) specialist could have better communicated to each other for continuity of care.

On March 2 a 75-year-old woman presented to her FP complaining of a persistent cough, dyspnea, night sweats, and cachexia for approximately one year that had worsened over the past month. The FP ordered a chest x-ray, which showed a right middle lobe infiltrate and a right pleural effusion. He suspected pneumonia, so a sputum culture was sent, and the patient was started on antibiotics.

When the patient's symptoms did not improve, the FP referred the patient to an ID specialist. The ID specialist started the patient on several broad-spectrum antibiotics. He also ordered blood cultures, serum antibody tests, and antigen tests to determine the pathogen causing the patient's pneumonia. However, none of the tests yielded definitive results.

On May 3 the patient's dyspnea continued to worsen. The ID specialist referred the patient to a pulmonologist for a bronchoscopy. The pulmonologist sent out additional specimens for multiple tests, including acid-fast bacilli stain and culture (AFB). The AFB would take up to six weeks to return but all other tests were normal.

On May 4 the FP received the results of the March sputum culture that was sent by her office. Findings were positive for *Mycobacterium avium* complex (MAC). The FP assumed the patient was still being followed by the ID specialist and filed the report with no further action.

On May 15 the pulmonologist referred the patient back to the ID specialist, advising him of the normal study results he had received. There was no mention that the AFB results were still outstanding.

On June 8 the pulmonologist received the AFB results from the bronchoscopy which confirmed growth of MAC. The lab did not send results to any other physicians. Nonetheless the pulmonologist believed it was the ID specialist's responsibility to follow up on the bronchoscopy culture results. Therefore, he did not communicate the AFB results to the ID specialist.

In October, over four months later, the patient developed low-grade fevers. The ID specialist referred the patient back to the pulmonologist on two separate occasions, but the pulmonologist never mentioned the AFB test results in his consultation reports. He did communicate that the results of the additional tests he ordered were normal.

In December the patient was admitted to the hospital for respiratory failure and expired within the week. The family filed a wrongful death lawsuit against the FP, pulmonologist, and ID specialist alleging failure to diagnose and treat MAC.



DISCUSSION

Experts disagreed about whether the FP or the ID specialist was primarily responsible for this patient's diagnosis and treatment. It was generally agreed that the ID specialist had the most liability exposure.

ID SPECIALIST

Experts were generally critical of the ID specialist for failing to follow up on the AFB culture results from the bronchoscopy. The ID specialist should have done something to obtain those results when the completed lab slips were not in the file. Failure to obtain the results was especially problematic when the patient was not recovering, and the physician did not have an etiology for the patient's problem. Experts also believed the ID specialist had a responsibility to obtain the culture results from the FP. Finally, they believed the ID specialist was responsible for coordinating the patient's care. He should have been the recipient of all the patient's information and lead diagnostician.

PULMONOLOGIST

Experts were critical of the pulmonologist for failing to communicate with the ID specialist regarding the bronchoscopy results, particularly when he treated the patient an additional two times following his receipt of the results. Because the pulmonologist received the results from the lab, it was incumbent on him to ensure appropriate follow-up. Experts further believed he should have made it clear in writing if he wanted to completely sign off on the case and delegate responsibility to someone else for following up on the results of the bronchoscopy.

FP

Experts' opinions were mixed regarding the FP's treatment of the patient. His main area of exposure related to failing to bring the sputum culture results to the attention of the ID specialist, particularly when the etiology of his patient's continuing problems could not be diagnosed.



RISK REDUCTION STRATEGIES

Consider the following recommendations:18

REFERRING PHYSICIANS

- Hand off patients to specialists with the same care, precision, and professionalism that you would like if you were the receiving physician.
- Have an office protocol in place for ensuring that you review consultants' reports.
- Establish a tickler system (either manual or electronic) to ensure the results of ordered tests are received and that all patients are informed of test results.
- Determine whether you, the consulting physician, or a different physician will coordinate follow-up treatment and ensure agreement from all.
- Continue to follow up with your patient after referral until a diagnosis is made and a care plan related to the referral reason is established.

SPECIALISTS

- When a referring physician hands off a patient with incomplete information, make efforts to obtain the information necessary to provide the best care possible.
- Be sure to have a full understanding of pending tests ordered by the referring physician including a plan to ensure visibility to results when available.
- Call the "sending" physician directly to discuss the patient.
 - ► Discuss pertinent tests and results, your impressions, and follow-up recommendations.
- Before referring back a patient, determine whether there are any outstanding test results or other reports that have not been discussed with the patient; obtain them before the patient's last appointment; and then discuss them with the patient.

All handoff communication should be documented in the patient's record. Informing patients of their diagnoses and telling them who will be coordinating future care creates a handoff communication safety net.



Smooth Transitions: The Importance of Handoffs for Continuity of Care

CONCLUSION

Consistent handoff practices can improve a clinician's ability to provide quality care, increase patient safety and patient satisfaction, and decrease liability risk. Implementing easy-to-use handoff tools and policies can result in better continuity of care for patients and clearer communication and teamwork among healthcare teams. The strategies discussed in this publication can provide the basis for creating a safe and effective handoff process for your organization. Taking time to regularly evaluate handoff practices and make necessary adjustments is an important part of ensuring it is a routine practice that continues to meet the needs of your unique healthcare setting.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at <u>RiskAdvisor@ProAssurance.com</u>.

This article contains content that originally appeared in the March 2022 Claims Rx entitled "Don't Fumble the Hand-off."

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