

PROFESSION

Emergency doctors promote patient handoff checklist

■ The initiative aims to counter the hectic pace in emergency departments that can lead to fumbled transitions of care.

By KEVIN B. O'REILLY ([HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY](http://www.amednews.com/apps/pbcs.dll/personalia?id=koreilly)) amednews staff — Posted April 17, 2013

A group of emergency physicians recently launched a website offering free tools designed to standardize the patient handoff process to reduce the risk of harmful communication miscues.

About half of so-called sentinel events — mistakes that result in death or serious patient injuries — involve errors that occur during handoffs in care, according to the Joint Commission. The problem is pronounced in the fast-moving arena of emergency care, where noisy environments, frequent interruptions and high-acuity patient loads combine to make handoffs a hazardous endeavor, said Drew C. Fuller, MD, MPH, an emergency physician who gave a presentation April 5 about the new handoff procedure at the Maryland Patient Safety Foundation's 9th Annual Patient Safety Conference in Baltimore.

"Handoffs are considered one of the riskiest procedures in the emergency department or any high-risk area in the hospital," Dr. Fuller said. "We wanted a system that invoked high reliability."

Dr. Fuller works for Emergency Medicine Associates, a Germantown, Md.-based provider of emergency medical services in the mid-Atlantic region. He and his colleagues at EMA developed the new handoff protocol, dubbed Safer Sign Out, which was finalized after surveying more than 100 of the company's doctors. It already has been implemented at 12 hospitals serviced by EMA in Maryland, Virginia, Washington, D.C., and West Virginia.

Checklist encourages vital communication

The key to the handoff protocol is the Safer Sign Out Form, a quality assurance tool separate from the medical record that serves as a checklist for the physician whose shift is ending to complete along with the physician taking over. The doctors note patient diagnoses, key issues, potential safety concerns and pending items. The physician signing out asks the doctor coming on shift the open-ended query, "What questions do you have?" to promote discussion.

The next step, ideally, is for the physicians to go together to the bedside to meet with patients about the plan of care. The final piece of the sign-out process is to relay that plan to nurses and other members of the care team.

"There's this comprehensiveness to it, because we're reaching out to the nurse and letting the nurse know who is signing out and what the big issues are," Dr. Fuller said. "Believe it or not, that's not common practice. This process gives everyone the opportunity to build teamwork and for the nurse to provide critical updates that the physicians might not be aware of."

The Maryland Patient Safety Foundation is partnering with EMA, the Emergency Medicine Patient Safety Foundation, and the American College of Emergency Physicians' Quality Improvement and Patient Safety Section to make the handoff tool, along with educational and promotional materials, available on the Internet ([link](#)).

Implementation has gone well so far, thanks to physician champions at the 12 hospital EDs where the Safer Sign Out process is being used, Dr. Fuller said.

“The first impression of some doctors when they hear about it is: ‘You don’t need to tell me how to sign out. I know how to do that, and I don’t have the time for this,’ ” he said. “Well, the average shift in emergency medicine is 500 to 600 minutes, and it takes me about five minutes to do this safer sign-out. I think my patients and my team are worth 1% of my time. When doctors realize how it can be done efficiently, it overcomes the initial resistance.”

Dr. Fuller plans to secure funding to study the sign-out tool’s effectiveness in improving the quality of handoffs and preventing errors.

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