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Simple Standardized Patient Handoff System that Increases Accuracy and Completeness

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Purpose

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines a â€œhandoffâ€ as a contemporaneous, interactive process of passing patient-specific information from one caregiver to another for the purpose of ensuring the continuity and safety of patient care. The purpose of this study was to conduct a comprehensive investigation on the determinants of an effective handoff management system. Specifically, we sought to address the following null hypotheses: There is no difference before and after implementation of a new, low-cost, low-tech process for surgery patient handoffs in accuracy of information, completeness, clarity of exact time of patient transfer, and number of tasks appropriately handed off.

Methods

Baseline description of the handoff process was mapped from 3 direct observation

sessions by an efficiency operations team. A focus group with residents, nurses, hospital administrators, and surgeons was held to identify concerns with the baseline process and to identify important features of a handoff system. These data were used to create an electronic survey for residents to indicate level of agreement with importance of various features and qualities of a handoff system. Longitudinal telephone surveys were performed with residents throughout and after the development period to determine the residents' perceptions of the completeness, accuracy, clarity of handoff time, and method of information transfer, as well as the frequency with which residents were expected to perform tasks that should have been performed by outgoing residents. An online survey was sent to residents before and after the new handoff system was implemented to study perceptions of information quality, process operations, clarity of responsibility, and satisfaction with the handoff process. Perceptions were rated on operationally defined scales. All instruments underwent expert review for content validity and clarity of instructions and scale definition appropriateness. A standardized, and partially automated, handoff form was then developed. After a 2-week pilot study, telephone surveys were repeated. Data were analyzed using descriptive statistics, the Student *t*-test, and multivariate analysis.

Results

Compared with baseline, residents reported increased accuracy, as measured by the perceived number of inaccuracies found on sign-out sheets ($p = 0.003$). Completeness of the information on sign-out sheets also was improved ($p = 0.015$). Clarity as to the time of transfer of care from outgoing (day team) to incoming (night float) improved ($p = 0.0001$). The type of rotation (intensive care unit vs non-intensive care unit) did lead to an improvement (confidence interval< 99%). Across both shifts, the perceived number of inappropriate tasks transferred decreased significantly. Experience (months of training) and type of rotation did not affect these measures.

Conclusions

By simplifying and standardizing the handoff instrument, we demonstrated improvements in resident perceptions of accuracy, completeness, and number of tasks transferred. This low-cost, low-tech paradigm may be useful to others.

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Key Words

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handoffs; surgical residency; patient safety; general surgery

Competency

Interpersonal and Communication Skills; Systems Based Practice; Practice Based Learning and Improvement

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